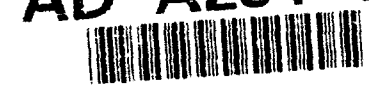


(1)

3 June 1994 Master's Thesis, 2 Aug 93-3 Jun 94

Army National Guard Medical Readiness Training Exercises in SOUTHCOM

Major Nancy A. Fortuin, ARNG

U.S. Army Command and General Staff College
ATTN: ATZL-SWD-GD
Fort Leavenworth, Kansas 66027-6900

Approved for public release, distribution is unlimited.

Medical Readiness Training Exercise (MEDRETES) conducted by military medical units in a field environment, where US military personnel conduct medical evaluation, treatment, and health education for persons who are not health care beneficiaries of the US government. The primary mission of these exercises is the training of military personnel. The Army National Guard (ARNG) has actively pursued these training opportunities which provide training in environments which closely approximate what they might experience in times of conflict. Over the past ten years the bulk of this training has occurred in the Southern Command area of responsibility. In 1987, the ARNG established a Field Medical Training Site in Panama which provided the process and infrastructure for medical units to deploy to Central or South America on 2-3 week annual training (AT) periods to participate in MEDRETES. The ARNG MEDRETE program in Southern Command provides an excellent case study showing how reserve component forces, while in an AT status, can serve as a vital resource to a CINC's peacetime strategy, as well as when mobilized in time of war.

SOUTHCOM, Medical Readiness Training Exercise, MEDRETE, Army 139 National Guard (ARNG), Military Civic Action, Humanitarian Assistance, Civic Action

ARMY NATIONAL GUARD
MEDICAL READINESS TRAINING EXERCISES IN SOUTHERN COMMAND

A thesis presented to the Faculty of the U.S. Army
Comand and General Staff College in partial
fulfillment of the requirements for the
degree

MASTER OF MILITARY ART AND SCIENCE

by

NANCY A. FORTUIN, MAJ, ARNG
B.A., University of Rochester, New York, 1977.
M.P.H., University of North Carolina at Chapel Hill,
North Carolina, 1983

Fort Leavenworth, Kansas
1994

Approved for public release; distribution is unlimited.

ARMY NATIONAL GUARD
MEDICAL READINESS TRAINING EXERCISES IN SOUTHERN COMMAND

A thesis presented to the Faculty of the U.S. Army
Comand and General Staff College in partial
fulfillment of the requirements for the
degree

MASTER OF MILITARY ART AND SCIENCE

by

NANCY A. FORTUIN, MAJ, ARNG
B.A., University of Rochester, New York, 1977.
M.P.H., University of North Carolina at Chapel Hill,
North Carolina, 1983

Fort Leavenworth, Kansas
1994

MASTER OF MILITARY ART AND SCIENCE

THESIS APPROVAL PAGE

Name of Candidate: Major Nancy A. Fortuin

Thesis Title: Army National Guard Medical Readiness Training Exercises in SOUTHCOM

Approved by:

_____, Thesis Committee Chairman
LTC Geoffrey B. Demarest, Ph.D.

_____, Member
LTC Dwain L. Crowson, MA

_____, Member
LTC Philip W. Wyssling, MBA

Accepted this 3rd day of June 1994 by:

_____, Director, Graduate Degree Programs
Philip J. Brookes, Ph.D.

The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

ARMY NATIONAL GUARD MEDICAL READINESS TRAINING EXERCISES IN SOUTHERN COMMAND by MAJ Nancy A. Fortuin, ARNG, 134 pages.

Medical Readiness Training Exercises (MEDRETES) are conducted by military medical units in a field environment, where US military personnel conduct medical evaluation, treatment, and health education for persons who are not health care beneficiaries of the US government. The primary mission of these exercises is the training of military personnel.

The Army National Guard (ARNG) has actively pursued these training opportunities which provide training in environments which closely approximate what they might experience in times of conflict. Over the past ten years the bulk of this training has occurred in the Southern Command (SOUTHCOM) area of responsibility. In 1987, the ARNG established a Field Medical Training Site in Panama which provided the process and infrastructure for medical units to deploy to Central or South America on 2-3 week annual training (AT) periods to participate in MEDRETES.

The ARNG MEDRETE program in SOUTHCOM provides an excellent case study showing how reserve component forces, while in an AT status, can serve as a vital resource to a CINC's peacetime strategy, as well as when mobilized in time of war.

ACKNOWLEGEMENTS

I would like to express my appreciation to all the people who spent their time answering my questions on the telephone. I would not have been able to pursue this undertaking if they had not been so generous with their time and knowledge.

I would also like to thank CPT Thomas Link for making charts for me. It is encouraging to know people who are willing to help just because it is their nature to do so.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER 1

INTRODUCTION

As part of the Total Force the Army National Guard (ARNG) has actively pursued opportunities for medical unit training in environments which closely approximate what they might experience during periods of conflict. Over the past ten years, the bulk of this training has occurred in the form of Medical Readiness Training Exercises (MEDRETES) in Central and South America. While the participating soldiers universally acknowledge this to be the most valuable training they have undergone, there is no consolidated record of the ARNG's role in MEDRETES nor is there analysis of how and why that role has changed.

Thesis Question

The primary research question addressed by this thesis is: How has the ARNG's involvement in SOUTHCOM MEDRETES evolved? The following secondary questions are also addressed: What are the implications for ARNG medical units in future Operations Other Than War (OOTW), and what are some of the drawbacks of involvement in the MEDRETE program?

Background

The ARNG has had two missions for many years. The first is the federal or wartime mission and the second is the state mission of mobilization and support in times of natural disasters or civil disturbances. The federal mission is resourced by the federal government and the state mission is financed by the state. The ARNG expends minimal resources on preparing for its state mission. The ability to perform that mission is seen as a by-product of training for war. With the publishing of the new FM 100-5 in 1993, the state mission has gained a new legitimacy as a classic example of OOTW. So much so that active duty units are now participating in missions that were once within virtually the sole domain of the National Guard (such as supporting the Hurricane Andrew relief work in Florida and Louisiana).

The ARNG is primarily a combat arms force composed almost entirely of field force units. This means that it is a field force. Medical units in the ARNG are perceived as useful for the state mission but primarily as a resource to support the combat arms units. Because they comprise such a small percentage of the force, medical units in the ARNG might be considered less prestigious because the "bread and butter" of the ARNG is its combat arms units. As a result, ARNG medical units are not often afforded realistic or useful training experiences compared to their combat arms counterparts. Given that all ARNG medical units are

designed for duty in the field rather than duty in a fixed facility, they regularly train in field environments. However, the extent of training is often confined to learning common skills tasks and military/wartime tasks. Medical units are seldom afforded the opportunity to practice their medical skills. This is because during training periods ARNG soldiers are not bonafide health care beneficiaries and are not entitled to care. Therefore, some medical soldiers' only opportunity to practice their medical skills is on mannequins and other such training aids. This is an especially significant training shortfall for the ARNG as many enlisted medical personnel do not work in a health-related field in their civilian jobs. As such, ARNG soldiers are usually dependent on their military training to prepare for their military jobs. One way the ARNG has helped remedy this shortfall is through the Medical Readiness Training Exercise (MEDRETE) program.

The military medical training that occurs in remote areas of the world began as a program that predated the operational use as defined in FM 100-5 as OOTW.[1] With the new emphasis on OOTW, this medical training has taken on a new legitimacy and is valued from multiple perspectives. Previously, medical care was seen only as a necessary tail to the important business conducted by the combat arms of seizing and retaining terrain or destroying the enemy's capability to conduct offensive operations. It is now

recognized that medics can go in and help win the hearts and minds of the people. Winning the good will of the people in foreign lands is often seen as more valuable to promoting our national interests than is controlling terrain through force or coercion. This concept was used during the Vietnam era but has since been refined and improved through the use of Medical Readiness Training Exercises (MEDRETES). For over 10 years the Army has performed MEDRETES in South America and Central America.

During the height of the hostilities between the Contra rebels and the Sandinistas in Nicaragua, the US administration nurtured a relationship with Nicaragua's northern neighbor, Honduras. Agreements were struck to allow the United States a military presence there. Troops were sent, and as always a medical element was deployed to care for those troops. The poverty of Honduras was apparent everywhere. As is their nature, the medical personnel felt compelled to utilize their skills and resources to care for some of the Hondurans. Legally, however, they were prohibited from treating anyone other than health care beneficiaries of the United States military, which the Hondurans were not. The medical element commander recognized the need to keep his people busy in the austere field environment.[2] He also saw an opportunity to increase his soldiers' clinical competence and to improve their wartime skills. He built a program allowing them to treat

patients who had illnesses and conditions unlike those they would see in their practice in the US, but similar to what they might see in times of conflict. The commander successfully argued that all soldiers need training under conditions as closely approximating what they might see in war as possible. He drew an analogy between his expenditure of medical supplies to treat Hondurans against the infantry's expenditure of ammunition and fuel to maintain their competency. He was successful in implementing his proposal, but only to the extent that it could clearly be determined that the medics were achieving some training value from the process. In short order, MEDRETES became to the Army Medical Department what the National Training Center was, and is, to combat units.

In 1985, the ARNG sent its first medical unit to the Joint Task Force Bravo in Honduras to train at the medical element. Since then ARNG medical units have been afforded the opportunity to train in peacetime under conditions they might experience in war. They treat real patients with a variety of injuries and illnesses under very austere conditions. The program has received rave reviews from units participating, and has been heralded as the highlight of many a medic's career.

The National Guard Bureau has chosen to support the training by dedicating full-time personnel on site to manage and support the program. The number of full-time ARNG

medical personnel working in Panama has grown from one officer in the early 80's to four officers and several NCO's today. Training is conducted in many countries in South and Central America. In addition, the official orientation has progressed from a program with a purely medical training orientation to one having a strategic focus. Of particular interest is an attempt to maximize benefits to all participants by considering the long-term impact on the health status of the communities in which the MEDRETES are performed.

As alluded to earlier, the MEDRETES can be evaluated at several levels. From the unit's perspective, the MEDRETES provide outstanding training thereby allowing the unit to meet its objective of training and being competent in all Army Training and Evaluation Program (ARTEP) tasks. From the strategic level, "MEDRETES are credited with helping to correct some of the root causes of instability that threaten democracies in Latin America."[3] In addition, the MEDRETE program has been approved by State Department personnel who have input on the selection of locations and scheduling of individual MEDRETES, thereby creating another channel for communication between the US and appropriate agencies within the host country. Increasing opportunities for communication and interaction between nations improves the chances for goodwill and cooperation.

The US Army Reserve (USAR) participation in the MEDRETES program has increased dramatically, yet the ARNG is the primary point of contact in SOUTHCOM for all Reserve Component medical training (including the Army Reserve, the Air National Guard, the Navy Reserve, and the Air Force Reserve). The ARNG is also taking the lead on expanding the program outside of SOUTHCOM. The National Guard Bureau, in conjunction with the State Department, has planned and implemented several joint MEDRETES in remote areas of Africa. Even more far reaching is legislation passed in 1992, championed by the ARNG, which allows National Guard medical units to go into medically underserved communities in the United States to perform MEDRETES.[4]

The ARNG, with its citizen soldiers, is truly a community based military force. As a result, the National Guard leadership considers ARNG medical units to be uniquely suited to provide a bridge between the military institution and communities, regardless of the borders surrounding those communities. The ARNG's success and leadership role in these missions seem to bear this perception out. The ARNG has a strong sense of community service and a proud history of support to civilian communities in need. While the Guard's wartime mission is more heavily resourced, its peacetime mission is what has historically separated it from other Reserve Component and Active Component counterparts.

This is perceived as a great strength, and a facet that should be utilized to the fullest.

From the perspective of the medical unit, good training is in, and of, itself a good reason to become involved in MEDRETES. Yet from the perspective of the former Commander in Chief of SOUTHCOM, General George A. Joulwan, there are other very valuable reasons to utilize the ARNG medical units in support of the SOUTHCOM mission. General Joulwan highlighted the value of MEDRETES in his 1993 statement to the Senate Armed Services Committee:

> The accomplishment of the SOUTHCOM mission relies heavily on personnel deploying to the region on a temporary basis . . . . US forces provide training to host nation counterparts or Deployments for Training (DFT) where the forces deploy to derive training benefit they would not be able to get elsewhere. These include numerous Humanitarian and Civic Action deployments - engineer, medical or veterinary. These deployments truly represent a "win-win" situation. US forces get unique training opportunities in environments that would be hard, if not impossible, to duplicate in CONUS, while the host nation receives much needed support which, in turn, contributes to stability, economic and social development, all of which strengthens democracy. These are classic examples of US military engagement in peacetime to support the sustainment of fragile democracy. And, the majority of these deployments are citizen-soldier deployments of our reserve component - the reserves and National Guard. . . . The National Guard and Reserve forces are absolutely vital to the mission in USSOUTHCOM.[5]

Implicit in General Joulwan's statement is the fact that, by using forces deployed to SOUTHCOM on a temporary basis, the CINC can accomplish his mission with a minimum of full-time forces in theater. He can minimize costs to the US taxpayer because he does not have all the costs involved

in maintaining a large permanent party force with the associated costs of dependents and living expenses. His forces must accomplish two medical missions. First, they must provide health services support to the permanent party personnel and their dependents. Second, they help to strengthen fragile democracies by providing services and ostensibly improving the health status of the populations of the countries in his area of operations.

General Joulwan can maintain the health of the permanent party personnel with a small medical staff. By necessity, the job is full-time with no opportunity for traveling the region to provide health care to non-military personnel. On the other hand, having reserve component units come into theater for 2-3 week periods year round is cost effective and provides trained personnel without the overhead costs associated with maintaining full-time personnel. The MEDRETE program runs very efficiently with a small full-time infrastructure to administer the program.

If the SOUTHCOM commander had unlimited resources, he might choose to increase his active duty force to meet the demands of this dual medical mission rather than involve the reserve component in MEDRETES. Yet there is another, less obvious reason to utilize the reserve components for the MEDRETE mission. It involves troop morale and its relationship to the success of MEDRETES. Medical care, more than any other military mission, is dependent on the

positive interaction between the soldiers and the civilians being served. Serving in MEDRETES also involves providing medical care and living in very austere environments. It involves seeing many cases and conditions which cannot be treated or cured under the auspices of the MEDRETE program. Health care providers are susceptible to burnout under the best of conditions, but the circumstances a health care provider encounters in SOUTHCOM might hasten this process. The risks of soldiers becoming jaded and resentful of being assigned on MEDRETES for extended periods of time is significant and apt to degrade the success of the mission. On the other hand, reserve component personnel see these missions as an exciting break from the usual annual training experience of providing site support at a familiar training area. As a result, units go into MEDRETES every time with a high level of enthusiasm and commitment. The soldiers remain excited about their work and provide a very positive impression to the community being served. The civilians see the US military in a benevolent role that shows soldiers are capable of being supportive rather than feared. Likewise, the local military in the country where the MEDRETE is conducted will see a very positive role model.

Aside from the overall value of MEDRETES to the military strategy of the US, we must also look at those benefits the ARNG derives from participating in the program. The National Guard has been locked in an ongoing battle with

the Army as to what the active component to reserve component mix should be. A critical component of this battle is the value of keeping a predominately combat arms presence in the ARNG. A strong case could be made for increasing the percentage of combat support and combat service support units in the ARNG. This argument is supported by the fact that combat service support units are thought to be of greater value in the state mission. Also, if the trend to OOTW continues, combat support and combat service support units are more apt to be utilized. There is general agreement over the fact that the reserve component combat support and combat service support (CS/CSS) units mobilized during Operation Desert Storm were fast deployers and combat ready to accomplish their mission.[6] It is readily apparent that the active component could not have accomplished their mission without the reserve CS/CSS units. In fact the ARNG has recently initiated a program whereby a limited number of CS/CSS units have been identified to deploy from home stations within 72 hours in support of humanitarian missions.[7] In addition, medical elements are always required in OOTW, either to take care of the troops deployed or to have a more direct influence on the situation. In fact, in the earlier days of the Bosnian crisis, the predominant US military support provided was a Mobile Army Surgical Hospital (MASH).[8]

History has demonstrated that public support for military operations is most complete and rapidly gained when the reserve components are mobilized.[9] Since reserve component CS/CSS units are easier to deploy than reserve component combat units, they are seen as more valuable in rapid deployments. Given the speed of contingency operations today, this is an important consideration. This, coupled with the CS/CSS benefit to state mission, provides a strong case to increase the percentage of CS/CSS units in the ARNG, at the expense of the combat units.

Aside from training for their federal mission, ARNG medical units have the added requirements of providing real world support. The demands put on the medical force structure in the ARNG are enormous. While the medical missions of the ARNG are increasing, the proposed force structure reduction is proportionately larger for the medical units than for the rest of the units. Traditionally, the States attempt to accomplish most of the military medical requirements using organic medical structure. Among other tasks, these requirements include cardiovascular screening for the over 40 population, physicals for the entire force at least every four years, immunizations on a regular basis, and site support. These requirements in, and of, themselves can be overwhelming, but at the same time the training opportunities are expanding to include MEDRETES in SOUTHCOM, Africa, and state missions

(midwest floods of 93, LA riots, Hurricanes Andrew and Iniki, and Ohio prison riot). Added to these requirements is the fact that the units must prepare and train individual soldiers in both common and job specific skills, Common Tasks Test (CTT), Military Qualification Standards (MQS), and Skills Qualification Test (SQT), and meld the unit into a viable organization, Army Training and Evaluation Program, (ARTEP). Medical units in the ARNG have become the victims of competing demands and diminished resources. But as a result of this and their outstanding performance in Operation Desert Storm (medical units were activated in numbers far in excess of their proportions in the force structure), they have gained new respect and consideration by the National Guard leadership. No longer is it the case that medics are expected to be present and well prepared when they are needed but remain out of sight and out of mind when they are not. With this new recognition comes a strong possibility of additional resources.

Assumptions

Data exists and can be accessed regarding the ARNG's participation in MEDRETES. Oral interviews provide an accurate source of information.

Definitions

Agency for International Development (AID). An agency under the State Department, maintains missions in

developing countries, works on long-term development projects in the host nation and oversees development efforts of any number of contract personnel from consulting firms and universities.

Army National Guard (ARNG). A Federal Reserve Component of the Army, whose soldiers are members of the Army National Guard of the fifty States as well as the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

Field Medical Training Site (FMTS). Organization and facility (Table of Distribution and Allowances) activated in 1987. Provided support to ARNG medical units to plan and execute MEDRETES in SOUTHCOM. Consisted of full time ARNG personnel (Title X) and prepositioned equipment. Located at Fort Kobbe, Panama.

Joint Readiness Training Center (JRTC). Training Center located at Fort Polk, Louisiana. Provides light units with the opportunity to train against an active opposing force. Units can choose from a variety of scenarios. All training is conducted in a joint environment.

Medical Readiness Training Exercises (MEDRETES). Training exercises conducted by military medical units in a field environment, where US military personnel conduct medical evaluation, treatment, and health education for persons who are not health care beneficiaries of the US

military. The primary mission of these exercises is the training of the military personnel.

Military Group (MILGP). Military personnel on embassy staff. Primary functions and responsibilities include: foreign military sales, military-to-military contact, and other US security assistance efforts within the host nation.

National Guard Bureau (NGB). Primary staff agency to the Department of the Army and the Department of the Air Force with many Major Command (MACOM) type responsibilities. Develops policies to standardize the operations and functions of the 54 separate National Guards, acts as a conduit for funding and communication between the Department of the Army and the States, and formulates and administers programs to ensure the continues development and maintenance of Army and Air National Guard units.

Non-governmental Organizations (NGOs)/Private Voluntary Organizations (PVOs). Agencies and organizations (usually from a developed nation) not affiliated with any government, working independently to promote development and well being in a host nation.

Southern Command (SOUTHCOM). Unified Command with area of responsibility incorporating 19 countries in South and Central America.

Theater Equipment and Maintenance Site (TEAMS). Organization and facility (Table of Distribution and

Allowances) activated in 1991. Expanded on the FMTS concept to include engineering readiness training exercises. Absorbed the FMTS and included US Army Reserve medical personnel.

Limitations

There is very little written on the ARNG's involvement in SOUTHCOM MEDRETES. Therefore, I have been dependent on personal accounts and information obtained through telephone interviews. While this is a valuable source of information it is likely to fall victim to fading or selective memories. While memories may not be exact, there is also the risk that key participants may have left the unit or retired from the ARNG, making them difficult to contact.

The responses to written requests for information was slow. Most of the people considered good sources of information travel a lot as a requirement of their job. Understandably, they may not have considered a request for information for an academic project as a very high priority. However, it is unlikely that resulting shortfalls had a detrimental effect on this thesis or significantly impacted on the basic question.

Delimitations

The scope of this project was automatically constrained in that the ARNG has participated in MEDRETES

for less than ten years. In addition, while there was a strong tendency to combine all the reserve components together, the preponderance of the questions referred to ARNG specific issues. The lessons learned by the Army Reserve were not eliminated from the discussion, yet the significant differences between the ARNG and United States Army Reserve (USAR) structure and ways of doing business proved important to the analysis. Therefore, the ARNG remained the primary focus.

Significance of Study

Given the current administration's burden to reduce spending, there is a reasonable assumption that more missions will be transferred to the reserve components as a more cost effective force. Also, as America looks for solutions to the health care problem, the public has a right to question why we are sending medical resources to third world countries when there is a valid medical need in the United States. Lastly, in light of the Army's recent emphasis on OOTW, this issue bears study.

CHAPTER 2

LITERATURE REVIEW

The readily available written references are adequate to support and assist with a significant portion of the analysis of the research question. However, a gap exists in the written documentation in that there is very little that deals specifically with the ARNG's role in SOUTHCOM MEDRETES. There are only two short articles pertaining to the ARNG's role in SOUTHCOM MEDRETES. One document addresses the early stages of the National Guard's involvement. It describes the building of the initial infrastructure for the program in Panama and the ARNG medical POMCUS site.[10] Another is a very general overview of the MEDRETE program.[11] While ARNG involvement in MEDRETES is alluded to in other publications and articles on medical civic action and reserve component training in Central and South America, the comments simply acknowledge the fact that the ARNG participates. These mentions are not of any significant value for the purposes of analysis. After Action Reports (AARs) on all ARNG MEDRETES done since 1987 are on file at the Field Medical Training Site (FMTS) at Fort Kobbe, Panama. (There is no evidence that AARs were written or maintained for ARNG units participating in

Medical Civic action or MEDRETES prior to 1987, when the ARNG established its own MEDRETE infrastructure.) However, access to AARs is limited in that manpower is not available to copy and mail the AARs to interested parties. According to the Chief of Medical Operations at the Theater Equipment and Maintenance Site, the AARs have been maintained but never consolidated or analyzed in a systematic fashion. Although the AARs are very detailed and comprehensive, there has not been a mechanism put in place to derive the lessons learned and incorporate them into improving the overall program.[12] While the AARs are not easily accessible, the original architects of the program are for the most part still members of the National Guard. Therefore, oral histories were the prime mechanism to document the history of the ARNG in MEDRETES. Additionally, widely disseminated periodicals, such as Soldiers or National Guard, have published many anecdotal stories with pictures on specific units performing MEDRETES. The primary purpose of these articles has been for the public affairs benefit as opposed to providing any analysis.

For ease of review, the readily available literature can be divided into the following five general categories. (Most of these papers/studies have been written in the past eight years. As such, the authors have tended to use the same sources as well as each other for references, giving a rather inbred impression to any specific category.)

1. Military Publications. Publications pertaining to the conduct and management of MEDRETES

2. Military Civic Action. Papers written to document and analyze the impact of military civic action

3. Military Medicine's Strategic Impact. Papers describing the strategic applications of military medicine

4. Force Structure. Studies analyzing the proper mix of active component to reserve component forces as well as the mix of combat to combat support and combat service support forces

5. Alternative Missions for the Army. Papers evaluating the concept of expanding the numbers and types of missions of the Army and the appropriateness of accepting alternative missions

Military Publications: HQ, US Army South (USARSO) and SOUTHCOM have published several documents (memorandum of instruction, regulations, and information papers) pertaining to the conduct and management of MEDRETES. These documents are of particular value to medical units about to embark on a MEDRETE. They provide the reader with a general appreciation for the requirements to prepare for, and conduct, a MEDRETE. Outlined are the program objectives, responsibilities of all parties, administrative and supply procedures, recommended manning requirements, and chains of command. An article useful to active duty units planning a MEDRETE was written by Captain Carter, a Medical Service

Corps officer with varied experience in executing MEDRETES.[13] Captain Carter laid out a fairly comprehensive checklist on how to prepare adequately for this unusual training experience. An ARNG unit would find value in the article for many of the lessons learned, though the ARNG administrative and planning processes often vary from active duty procedures.

Military Civic Action: One of the most valuable resources in this category is a well-researched and analyzed work covering military civic action in Honduras from 1982 to 1985.[14] This work assesses the value of military civic action from the tactical and strategic levels using medical civic action case studies to illustrate the thesis. Another valuable resource is a compilation of independent chapters edited by DePauw and Luz under the title of Winning the Peace: The Strategic Implications of Military Civic Action.[15] Chapter seven (Reserve Components' Role in Civic and Humanitarian Assistance) is particularly illustrative and useful in that it lays out a strong rationale to continue such programs as MEDRETES with strong reserve component representation.

Military Medicine's Strategic Impact: Several authors have made very compelling and thorough cases about the impact of military medicine on strategy. One of the most valuable of these is Colonel Robert Claypool's overview of military medicine as an instrument of power.[16] This

study provides an excellent history of the use of military medicine at the strategic level and the associated outcomes of that use. Specific case studies are provided and each study is thoroughly analyzed with the costs and benefits of each itemized. Most importantly, criteria to be considered before involving military medicine at this level are proposed. The intent of the criteria is to provide a framework to evaluate the possible benefits of a project prior to committing the resource of military medicine. Another seminal work in this area was produced by Colonel ElRay Jenkins who describes in excellent detail the evolution of Medical Civic Action Programs (MEDCAPs) and MEDRETES in Honduras.[17] He uses the Vietnam era MEDCAP program as a model to describe the involvement of the military medical community in low-intensity conflict and how the model can be refined to help counter insurgencies. Of particular value are his recommendations for evaluating the program to insure its continued usefulness. Colonel Jenkins also gives a very good description of the budgetary concerns surrounding MEDRETES. Another important paper documents the success of medical mobile training teams in El Salvador toward countering insurgency.[18] Also of note is a paper by Lieutenant Colonel Taylor on the role of military medicine in low-intensity conflict. He discusses how minimal expenditure of resources at the lower end of the conflict

spectrum can reduce the possibility that the conflict will escalate, requiring much larger expenditure of resources.[19]

Force Structure Mix: The success and value of the Total Army has been under discussion for many years. The ratio of active component to reserve component drives end strength and the associated missions which the components are capable of handling. As the end strength is reduced overall, the ratio of combat arms to combat service support and combat support becomes critical, especially with associated concerns about strategic lift and the ability to fight two nearly simultaneous major regional contingencies as current policy dictates. The increase in missions under the category of OOTW has put these issues under the spotlight. It has become apparent that our ability to provide the requisite CSS forces is in question. Several authors have addressed the force mix ratios and their impact on missions and strategies. Of particular interest is a paper by Colonel Thomas Sewell, in which he addresses reserve component training in SOUTHCOM and how the reserve component has expanded the capability of the CINC with minimal expenditure of resources.[20]

A study by Charles Heller examines the detrimental historic tendency to drawdown the military after conflict and when the economy is fragile. While looking at the relationship between the active and reserve components he considers the need to consider strengths and weaknesses of

the components and how our current strategy impacts on our force structure.[21]

Alternative Missions For the Army: Shrinking resources and absence of a definable threat have put the Army into a position of redefining itself. In the foreground of considerations are domestic problems and OOTW. Several authors have suggested that the Army look beyond its normal mission of fighting traditional war and consider new ways to use its vast resources. Senator Sam Nunn presents a convincing argument that the military should become more flexible in its approach to accepting and seeking out missions while maintaining its traditional strengths and missions. The thrust of his presentation is to promote his concept of a domestic civil-military cooperative action program for which he proposed supporting legislation. He cites as examples a number of programs which have already been implemented that could be expanded and institutionalized. He suggests that since the warning time in future conflicts will be longer there is less need for combat forces in the ARNG. He goes on to make a case to increase the number of Combat Service Support (CSS) or logistic type units in the ARNG. While arguments could be made to contradict some of his conclusions, he makes two strong points. The Army will have to become more innovative in our training as resources are reduced and that anytime a dual benefit can be achieved it should be pursued (such as

acquiring flight time on real life medevac missions).[22] Brian Ohlinger[23] and Philip Brehm[24] make similar cases as Senator Nunn, providing thorough documentation and analysis to support their conclusions.

CHAPTER 3

RESEARCH METHODOLOGY

The primary undertaking of this thesis was to document the history of the ARNG's involvement in SOUTHCOM MEDRETES. As noted previously, there is a significant literature gap in this area. Fortunately, the majority of the primary players involved in establishing the ARNG medical presence in SOUTHCOM are still in the National Guard and readily accessible by telephone. Therefore, telephone interviews were the primary mechanism to obtain historical accounts.

The next undertaking was to look at the political aspects of MEDRETES by viewing from the following three perspectives:

1. The first was the interaction between the US military and the governments of the South and Central American countries where MEDRETES occur. Contact was made by telephone to personnel in two South and Central American MILGPS.

2. The second perspective was an examination of the interplay between the ARNG and the active component military players in the MEDRETE planning, implementating and evaluating process. This entailed making contact with the

key players, past and present, in the infrastructure which manages MEDRETES to include the SOUTHCOM surgeon's office staff.

3. The last was to look within the ARNG itself and at the competing factors which have come into play concerning the overall ARNG support and level of participation in the program. A written request for information was sent to the Director of the ARNG. The previous Chief of the National Guard Bureau, Lieutenant General Temple, was interviewed by telephone. This was done in an effort to learn if there was a well-defined official policy and strategy regarding the National Guard's involvement with MEDRETES, as well as to determine what factors shaped that policy and what the level of commitment has been and will continue to be in the future.

The MEDRETES can be considered a program that has been applied at both the strategic and tactical level. The institutions and organizations contemplating the use of a program normally use a program planning model to reap the most benefit from their investments. Most such models incorporate several stages in the process. The most common stages include goal setting, needs assessment, objectives, planning, implementation, and evaluation. This model was used as a mechanism to assess if the program has been well defined and managed.

In conclusion, MEDRETES cannot be assessed from only one perspective or angle given that they meet more than one need and are implemented for a multitude of purposes. Therefore, the research for this thesis followed three approaches. First was the history and background of the ARNG in the MEDRETE program. Second was the overall impact, both political and as it affects the health of the people in the communities where MEDRETES have been executed. Lastly, the viability of the ARNG remaining involved in MEDRETES given the force structure and competing demands on medical personnel and units, was examined. The resulting conclusions can be used to make recommendations as to the future of the ARNG's involvement in the program.

CHAPTER 4

ANALYSIS

The MEDRETES on the surface seem to be a win-win situation for all concerned. The countries in which they are conducted get increased health care; the US military gets trained; and even our national interests are served by helping to strengthen fragile democracies. Yet a closer look exposes some questions of the impact of MEDRETES. For instance, does the introduction of US military medics undermine the authority of itinerant healers in the community? There is evidence to indicate that a train-the-healer program has far more positive benefits than providing direct health care. Also, has the US military made a reasonable attempt to merge the goals of training our soldiers and providing a stabilizing influence by improving the health of the community? Raising expectations with miracle cures can backfire when those cures are short lived, (such as prescribing antibiotics with no follow-up care to insure compliance with the regimen). It can have detrimental long term implications on the faith of the people in the program. Also, has quality assurance been fully integrated into the program? In the name of training, are patients medically taken advantage of by allowing medics

to conduct procedures and provide care that does not meet the US standard of care? Is the military working in concert with other US agencies working in the region, such as the Agency for International Development or Peace Corps? Is there an unnecessary redundancy of effort, or worse, are the programs working at cross purposes? Additionally, since the MEDRETES are coordinated through State Department channels, do politicians in the targeted countries manipulate the locations of MEDRETES to gain political favor for themselves? Lastly, by having Citizen Soldiers experience conditions in third world countries first hand, do they return to their communities with a greater appreciation for what they have? Are they more willing to support international assistance by the US? We have an obligation to both the American taxpayer and the people we treat to examine these issues and come to a reasonable conclusion on overall costs and benefits of the program.

History of Medical Civic Action/MEDRETES

Medical Civic Action Programs

Military medical personnel have historically provided medical care on the basis of need, rather than on the basis of specific unit or other identity. That propensity is limited only by laws and resources. This is reflected in doctrine, such as the doctrine that support is provided on an area basis versus a direct support basis.[25] It is further evidenced in the fact that medical care is provided

to Prisoners of War (POWs) on an equal basis to our own troops, as directed by the Geneva convention and outlined in Army doctrine.[26] This medical egalitarianism is ingrained in the mores of the medical profession as manifested in the Hippocratic oath. The tradition and propensity to broadly provide health care exists at the core of the health care profession and culture.

The Army's significant medical force structure has as its primary mission to provide for the health of soldiers and their families during war and peace.[27] The Army medical units, along with some other support units, are somewhat unique in that they must also provide a service during peacetime. Many other units have the luxury to spend the preponderance of their time training for their wartime mission. This dual mission requirement causes medical units to be creative with their training and attempt to maximize any training opportunities.

Military leaders have historically found ways to capitalize on medical personnel's natural propensity to provide care for whomever needs it and to formalize and legitimize this care giving by using it to serve as an instrument of national power.[28] Although it is difficult to assess the success of this versus any other instrument in isolation from one another, its use remains a very popular and palatable strategy to influence a country's perception

towards the US. military and by extension, their attitude toward the United States.

Examples of the use of military medical assets as instruments of national power are numerous. In the 1940s, Korean and US medical personnel trained together, and the US sponsored and staffed a Korean Army medical school. In addition, the US Army arranged for training of Korean military personnel in US medical schools.[29] In the 1950s, then Surgeon General Lieutenant General Heaton was sent by the Army Chief of Staff, General Taylor, to provide health care to the prime minister of Thailand. (Subsequently air base rights were secured in Thailand.)[30] During the Vietnam war, one of the most famous uses of medicine as an instrument of national power was implemented in the form of the Medical Civil Assistance Program, better known as MEDCAP. An objective of the program was to win the hearts and minds of the people in support of the central government of Vietnam.[31] In 1987, as a gesture of goodwill and support, President Reagan offered Mrs. Aquino, the elected leader of the Philippines, the services of the USS Mercy, a US Naval hospital ship to provide care for her people.[32] In 1992, a Mobile Army Surgical Hospital was sent to Zagreb, Croatia (part of the former Yugoslavia) as the primary and most visible US military contribution to the United Nations efforts in that war torn region.[33]

While all these programs, on first examination, appear to be at best altruistic and at worst an opportunity for US military personnel to get valuable training while providing a modicum of care to individuals who might not otherwise get any, it must be remembered that these exercises and undertakings are initiated with specific objectives in mind. Sometimes the outcomes of these undertakings can be unexpected and sometimes the effects are detrimental, whether or not the original objectives were achieved. Given that we must carefully consider all the impacts that medical intervention may have, Colonel Claypool[34] has concluded that, "It is in our best interests to assist developing nations to improve their health status so that they are free to realize the economic health and all the political, social, and human rights benefits that accompany it."[35]

Medical Readiness Training Exercises

The US military has a strong tradition of using its medical resources outside their primary role/mission of providing medical care to soldiers and their family in peace and war. The medical civic action program in Central and South America has outlasted any other. (The MEDCAP program in Vietnam began in 1963 and funding ceased in 1972.)[36] While the SOUTHCOM program has taken several forms and has undergone significant evolution, it is still a popular and well supported program.

The MEDRETE program in SOUTHCOM is unique in that it is not just a single response or short term solution to a problem. Rather the program has become institutionalized at a number of levels. The CINC SOUTHCOM has gone on record saying that medical civic action is a viable and vital part of his overall strategy in the region.[37] Medical units, particularly reserve component units, have grown used to having this valuable training opportunity available. Because the program is so long lived, training managers can routinely program units into this training. This has not always been the case. (MEDRETES seem to have a far more positive image than the Vietnam MEDCAPS had. This could be because reserve component personnel are the primary players, and therefore the true value of the exercises is reaching the people rather than the population being suspect of the motives of the program.)

The precursor to MEDRETES in the Central and South American region occurred during the 1960s when President Kennedy sent Special Forces troops to Latin America to perform civic action as part of a counterinsurgency strategy. Some of the assistance provided was instruction on veterinary medicine and sanitary engineering.[38] In 1983, Honduran and US forces combined to do medical civic action in rural areas of Honduras. This was done as an adjunct to military operations and was designed to broaden counterinsurgency efforts in Honduras. Medical civic action

continued through 1984 and expanded as part of every major military exercise conducted. These efforts proved to draw large crowds of individuals seeking basic medical care.

The 193rd Brigade in Panama was not medically staffed to provide support to all the engineer exercises occurring in SOUTHCOM. Consequently, US Army South began to actively seek state side resources. A US Army Reserve headquarters (CONUSA) or National Guard state headquarters became responsible for providing the support and personnel resources for a particular exercise. The medical support was intended primarily for soldiers participating in the exercise, but medical personnel were also tasked to conduct incidental civic action within a 50-mile radius of the base camp. (This had to be done without compromising the health of the US troops.) Reserve Component medical cells/units were rotated through these exercises every two weeks. The exercise usually lasted six months. A core staff, which included about six medical personnel (including at least one physician), would stay for the duration of the exercise to provide the requisite continuity.[39]

These MEDCAPS proved very popular. Yet with each rotation of exercises, funding problems delayed the initiation of the MEDCAPS. The engineering exercises were funded for medical supplies to treat US troops. Title 10 funds were required to procure medical supplies for the MEDCAPS. While the money was always forthcoming, it was

usually two to three weeks into the exercise until MEDCAP supplies could be purchased. In the meantime, the medical planners were pressured by both the Embassy staff and SOUTHCOM staff to start MEDCAPs immediately, even if it was just to hand out bandaids. The medical planners resisted doing this, believing it would do more damage than good. Instead they made every attempt to procure supplies in sufficient time to properly administer the program.[40]

In 1984, most medical civic action in Honduras converted to MEDRETES which were training exercises independent of other military operations. The fact that the primary purpose of MEDRETES was, and is, training for medical units became a critical difference between them and other medical civic action programs. This distinction was especially important when military activity in SOUTHCOM came under stringent review by the General Accounting Office.[41]

There were several lessons learned during the initial stages of the MEDRETE program. A less than obvious problem was the fact that to garner the full potential of the program it was important to have media coverage.[42] It was also learned that the military could not and should not plan these programs in isolation. Rather, numerous organizations should be involved in the planning and coordination. These agencies include the host nation government, Agency for International Development, non-governmental organizations, and associated international agencies.[43]

In 1985, the first reserve component unit participated in a SOUTHCOM MEDRETE. (A medical company out of the Illinois ARNG did the first stand alone MEDRETE, independent of any engineer exercise, in Bolivia.)[44] Since 1985 the preponderance of units participating in MEDRETES has shifted to the reserve components. This was as a result of the decrease in Medical Civic Action programs due to Congressional funding limitations.[45] The primary purpose of a MEDRETE must be training. The participating units must understand this to preclude inadvertent misuse of government assets. It is abundantly clear that there are a number of additional benefits derived from MEDRETES, but these must remain incidental to training. The ARNG quickly saw the merit in this program and built and maintained an infrastructure in Central America to continue the program.

Interaction Between US Military, State Department (AID), and Other Governments Where MEDRETES Occur

The President of the United States prepares the National Security Strategy as a blueprint to guide effective use of the instruments of national power. The 1993 National Security Strategy makes a case for building government institutions to serve the future. Specifically it says,

> coordination within the government can be improved; duplication of activities should be eliminated. We need to re-examine the entire government apparatus--agency structure, personnel and practices--to ensure the most efficient policy making under new conditions.[46]

The planning, implementating, and evaluating of MEDRETES provides a case study of how well the agencies of our government coordinate and pool resources to achieve a common goal.

The Foreign Assistance Act of 1961 gives the Secretary of State overall responsibility for coordination of military and foreign economic aid.[47] Under the Act for International Development, the Agency for International Development (AID) is tasked with promoting long range health care in third world countries.[48] In a September 1993 memo from the White House, AID's primary role was emphasized by establishing the Administrator of AID as the President's special coordinator for international disaster assistance.[49] So by statute, AID, under the auspices of the State Department, is responsible for promoting maximum effectiveness of all US agencies involved in long-term development activities as well as disaster relief.

The ability of the US agencies involved in health care programs in SOUTHCOM to work together and establish a synergy of effort appears to be in an infant stage. (This assessment does not even take into account US based non-governmental agencies providing health care programs.) Given that all US governmental agencies involved in any capacity with nation assistance are doing so in support of the National Security Strategy, one should assume that we are all working toward the same end. However, the different

branches of the service still do not always work together as efficiently as envisioned by the Goldwater-Nichols Act of 1986.[50] For example, in late 1993, the Army ran a workshop to look at roles and possible doctrine for the Army in humanitarian relief efforts (specifically medical issues). Mr. Lyerly, a staff member from AID, known to be knowledgeable in disaster relief efforts, was invited to be one of their speakers. Two months later Mr. Lyerly received a call from Navy personnel who were looking at the same issues. He suggested to the Navy perhaps they should contact the Army who had a two month head start. Mr. Lyerly was thanked for his recommendation, but was told that this was a Navy undertaking and indicated lack of interest in coordinating with the Army.[51]

Even with the advances realized after the passage of the Goldwater Nichols Act, there is still internal resistance to the military services working together. If the services resist working together, it is no wonder other US governmental agencies have difficulty working in concert with each other and with the military. Although not a perfect system, the military has the benefit of a warfighting CINC with a significant staff to coordinate the efforts of all services. In SOUTHCOM, the staff element with primary responsibility for coordinating MEDRETES throughout the region is the SOUTHCOM Surgeon's Office. In fact, it is the responsibility of the ARNG advisor to the

SOUTHCOM Surgeon to prepare the five-year plan for all medical humanitarian assistance, which includes scheduling of all Army, Navy and Air Force involvement.[52] One ARNG advisor discovered the lack of unity between government agencies when he attempted to obtain the ten-year plan developed to support the Ambassador by AID and the Defense Attaché Office. His intent was to overlay the SOUTHCOM Surgeon's five-year plan with the Ambassador's ten-year plan, thereby helping to establish a greater unity of effort. However, personnel in the Defense Attaché Office were less than cooperative in this effort.[53] While one would hope that this was an unfortunate and isolated example, there is evidence to indicate that the CINC's staff and the Ambassador's staff have much room for improving their cooperation and therefore of efficiently promoting the strategic interests of the United States.[54]

The SOUTHCOM Surgeon's staff works through the MILGP to coordinate MEDRETES. The MILGP attempts to gain an audience for the SOUTHCOM Surgeon's staff with high ranking individuals within the host nation, such as the secretary of health. CINC staff members who have primary responsibility for MEDRETES, often have direct access to the highest levels of decision makers in the host country. In this manner the CINC in essence has great latitude in his ability to run the MEDRETE program as he sees fit to further his regional goals. This is not to say that the planning is done in

isolation. The SOUTHCOM Surgeon's representative must first present the program to the MILGP. Usually in attendance at these meetings are representatives from AID. While not strictly defined by law or practice, MILGP personnel are normally the CINCs day-to-day means of interface with the Ambassador and other State Department representatives.[55] As such, the MILGP should coordinate and staff all MEDRETE activity through the appropriate persons on the ambassador's staff. However, allowing the CINC's staff to coordinate directly with the governments of host nations has the potential to dilute the ability of AID to manage long term development programs.[56] (For instance, a National Guard unit doing a MEDRETE in Bolivia dispensed a significant amount of vitamins without doing proper coordination. The ARNG unit members thought they were being helpful and did not realize the implications of their actions. When AID found out the extent of the program they realized the intervention had wrecked havoc with a longitudinal nutrition study being done by a non-governmental agency.)[57] On the other hand it allows the CINC great freedom in managing his regional medical program. (All MEDRETES funded under Title X must contain a statement verified by AID that the program will not duplicate any other US funded or sponsored program in the country.)[58]

Remembering the fact that AID is the US government agency responsible for long-range development, there seems

to be little attempt by AID to harness the potential benefit the US military is providing via MEDRETES. While the military is good at strategic planning, Lieutenant Colonel Rios, Chief, Policy and Strategy Division at SOUTHCOM, finds the agencies he works with in SOUTHCOM's area of responsibility do not plan more than six months out and no one is orchestrating the efforts of everyone to a common goal.[59] After working two years in the position, the Chief of AID's Bureau for Health, Population, and Nutrition for Latin America and the Caribbean was unaware of the fact that the US military performed MEDRETES in his region. He only became aware of the existence of MEDRETES when the SOUTHCOM Surgeon requested a meeting to discuss them in January 1994.[60] (It must be remembered that the military is constrained in that the primary purpose for MEDRETES is for training US troops and that any humanitarian or developmental benefit is incidental to the training aspect.)[61]

The parties involved in the planning of MEDRETES do make an attempt to derive double benefit from the exercises without detracting from the training benefit or incurring extra costs. Specifically, the MILGP will nominate humanitarian missions to the CINC on both a yearly and five year planning basis. A MILGP might determine which host country's military service needs to look good to the population and would request the like US service to conduct

the MEDRETE.[62] In addition, the J-5 staff in SOUTHCOM uses a Regional Security Strategy Implementation Analysis computer program to accomplish a cost benefit analysis in order to prioritize the placement of MEDRETES. This program allows the staff to input the nominated MEDRETE projects and run them against a number of subjective criteria (GNP, debt, prospects for growth, literacy rates, etc.) to assist the CINC in his decision making process. The program enables the CINC to place his limited resources in areas where he will get the greatest impact for his regional strategy while not taking away from the training benefit.[63]

As the resources are further diminished and the coordination and cooperation between governmental agencies becomes more crucial, the military appears to be taking the lead in making this coordination happen. In fact, inter-agency coordination is viewed as an economy of force by the SOUTHCOM Surgeon's office.[64] The Army and Navy are beginning to write doctrine to guide their respective services in the area of OOTW, and are actively seeking AID's input.[65] The Marine Corps is running no-notice interoperability exercises with organic civil affair groups role-playing the part of private voluntary organizations (PVOs), and have asked for AID input and evaluation.[66] In the first rotation of fiscal year 1994, the Joint Regional Training Center (JRTC) ran a disaster relief exercise with actual representatives of PVOs participating as part of the

scenario, (including the International Red Cross, World Vision Relief, Care, and Save the Children).[67] Both the military and the PVOs learned a lot and want to continue the training relationship. It was the first time the PVOs worked with the military in a non-controversial environment. The previous CINC SOUTHCOM lived the motto "One Team One Fight," meaning that he expected all efforts to support the National Security Strategy in his region. He held Ambassador conferences in an attempt to coordinate efforts and reduce duplication of effort.[68] The previous SOUTHCOM Surgeon would invite the Surgeons General of the countries in the region to a Surgeon's Conference. One of his objectives was to obtain their opinion of the impact of MEDRETES on the health of their nations.[69]

Reduced resources generally lead to competition among the competing players. Yet there appears to be a trend developing whereby the military, other governmental agencies, and NGOs/PVOs are recognizing that today's circumstances dictate they all working side by side on the same projects and ultimately to the same ends. The need for this cooperation is highlighted in an article by a prior Peace Corps volunteer who poignantly describes her interaction with personnel from the medical element at JTF-Bravo in Honduras. She starts out by saying that, "no one tells us if or how we should interact [with the Army] overseas." She goes on to describe instances where US Army

medics made very bad impressions on the local population. She concludes with well reasoned recommendations on how to improve the situation.[70] The world is a smaller place by virtue of communications and other technology. Additionally, the world has changed as a result of the conclusion of the cold war. These two facts have been instrumental in defining how we all do business today. As a result of these facts and the increased cost of doing business, the logical direction is for agencies with common goals to work together to achieve synergy of effort and a better quality of outcome.[71]

Evaluation

A program must have value to be maintained. The value of a program can be determined in a multitude of ways. The value may be perceived only or it may be supported by objective evidence. The customer or client may value a program for one outcome, and the program planner and manager may value it for quite a different reason. Regardless, in a period of diminishing resources, a program that does not demonstrate value is unlikely to survive. During the 1980's, money in support of the military was relatively abundant. A program with an implementation plan stood a reasonable chance of funding. This was the environment in which both the Army and the ARNG initiated MEDRETES in SOUTHCOM. In the 1990's, as the budget is reduced, all programs must be carefully scrutinized to insure that the

expected and demonstrated value is at least as significant as the resources used to support the program.

To reasonably evaluate a program there are several criteria to be met. A structure must be put in place during the planning process to determine the criteria to be used in the evaluation. First a needs assessment should be accomplished to insure that there is a valid need for the program and to determine if there are any other needs that should be addressed. (The fact that the medical personnel needed training established this need.) Second, the objectives should be determined. The objectives should be written in a fashion so that their accomplishment can be measured. The measurement criteria must be carefully planned to insure they are reliable and valid. (ARTEPs and SQT test are accepted by the Army as a measurement of individual and unit training.) Only then should the program be fleshed out and implemented. The outcomes should be evaluated and the program revised as necessary to improve the outcome. This process is by design cyclical and never ending until the program outcomes no longer meet the stated objectives. Many would argue that no program should be implemented without formally going through this process.

It is unclear if the architects of MEDRETES went through this process in anything but a cursory fashion. Today we are left with trying to determine if the program is still or ever was a good idea, or if it has outlived its

value. Without knowing the original goals and objectives, it is difficult to trace the reasons for the evolution of the program, nor can we absolutely define its success. Instead we are left to study data that was not maintained in a systematic manner and attempt to define success and value after the fact.

If an objective of the program was to have a positive impact on recruiting and retention in the ARNG, measurable evaluation criteria might be a survey of all participants to determine their top three reasons for staying in the ARNG as well as a control survey to see if those leaving the ARNG ever had a MEDRETE experience. Another survey could be done to see if the prospect of going on a MEDRETE had any impact on a decision to join the ARNG. The recruiting and retention community is the best one to measure this outcome in that these decisions are very complex, and they have access to sophisticated methods to determine answers to questions such as these. The Army and ARNG have established medical professionals and technicians in storefronts and armories across the country to recruit health care professionals, yet some are not able to recruit even one physician per year. Knowing the impact of MEDRETE participation might prove to be very cost beneficial. The ARNG has never done focused research to see if MEDRETES or Overseas Deployment Training (ODT) has any impact on recruiting/retention of health care professionals. However,

it is generally accepted by ARNG recruiters in the field that MEDRETES are considered a major opportunity and have a positive impact on retention.[72] The ARNG has predominately featured pictures and descriptions of MEDRETES in its recruiting literature.

The primary objective of the MEDRETE program, and in fact what the program is limited to by statute, is to train medical soldiers. In many respects, this is a much easier objective to evaluate because the Army measures unit and individual expertise through use of the Army Training and Evaluation Program (ARTEP) and Skill Qualification Tests (SQT) respectively. Success on these evaluations can not be conclusively traced to a single training event. However, with enough numbers and consistent successes, participation in MEDRETES can be linked to them as a valuable training event. There are a couple of issues in this arena which must be more closely analyzed. First, in cases where the primary purpose of the MEDRETE is to give immunizations, it is questionable how much training a medic gets. It does not take many repetitions to become trained on giving shots. Also, in many cases the unit or cell embarking on a MEDRETE does not pack and use their own unit's equipment but finds the necessary equipment and supplies prepositioned for them at or near the village where the MEDRETE is to be performed. This is a time saving factor because the infrastructure in place to support MEDRETES stores, maintains, and transports

the equipment and orders the necessary supplies. Therefore it is inappropriate to claim that the participating unit gets the full benefit of training to go to war by preparing to mobilize and move to an austere environment. In addition, many of the diseases seen by the indigenous population are not apt to be the same as we would normally expect to see of our soldiers in a wartime scenario. Also, entire units are less apt to participate in MEDRETES than cells from units.

On first examination, it appears that the training benefit of MEDRETES might be overstated. If the unit does not train as a unit, mobilize with all its equipment, and treat combat casualties, it is more difficult to draw a strong link between the MEDRETE experience and that of going to what we normally think of as war (that which is fairly high on the spectrum of conflict). Yet, as already discussed, the training environment provided under the conditions of a typical MEDRETE is far more comparable to what a unit would experience during war than anything currently provided in more traditional medical training scenarios. In addition, MEDRETES have the added benefit of being virtually identical to what units might experience in OOTW. Given that many medical units and medical personnel are probably more likely to be involved in an OOTW situation than a more traditional conflict, the benefits of MEDRETES become more pronounced.

Another objective in MEDRETES is to help improve the health of the population. Although not impossible, it is very difficult to link MEDRETES as a health intervention to a community's health status. In an attempt to make such a linkage, program managers have counted the number of teeth pulled, the number of people in a health education class, or the number of procedures performed in order to assess the success of the program. Unfortunately these are not valid criteria against which to measure the health of a population or nation. Traditionally a nation's health is assessed by looking at such indicators as infant mortality rates, nutritional measurements, and life expectancy. Here again, there are many factors which impact on the health of a community and a MEDRETE is one small component. It would take a very sophisticated measurement instrument (and significant resources) to accurately isolate and measure the actual impact, if any, of a MEDRETE on a community's health status. Regardless, without such a measurement, it is presumptuous of the military to claim that MEDRETES have any positive impact on the health of a community.

On the same note, the military links the health of a nation as one component of that nation's ability to sustain a democratic form of government. Here it may be valid to look at historical examples comparing health demographics to stable or democratic forms of government. Politicians and economists have not settled the discussion of which comes

first, a growing economy or a stable, democratic government. In all likelihood the truth is probably that both conditions interact with one another in what might be a beneficial or detrimental fashion.

Lack of valid evaluation measures has been identified as a flagrant weakness in the MEDRETE program. Major Bernard Harvey identifies the public opinion poll as the basic, if deficient, tool of measure. Yet public opinion polls are fairly simple to implement and can provide significant insights into a groups current perception of an activity. He goes on to suggest that the Department of Defense (DOD) and the State Department should take responsibility to undertake scientific studies in order to predict the outcome of assistance interventions.[73] Colonel Robert Claypool also cites lack of valid evaluation as a problem when using medical forces outside of their primary mission. He has established criteria to screen potential missions and therefore help select strategic missions for the AMEDD. This selection process would cause the military and the government to bypass missions which would not render sufficient returns on the investment. His objective criteria include: missions requested by the host government, joint training opportunity, opportunity for intelligence gathering, and opportunity to train friendly foreign nationals. He also recommends the subjective criteria of trusting the decision maker's intuition! Some

selection criteria used to reject an opportunity include: when the venture is only a showcase opportunity, where the population does not want us, where we may compete with the local healers, when only one visit is planned, when there is no opportunity for follow-on care, when the US does not continue to provide and there is no substitute, and when the project is very costly with minimum impact.[74] In his study, Colonel Jenkins states that the recipients of early MEDRETES in SOUTHCOM perceived the program as a massive give away. "Regardless of the humanitarian intent of alleviating human suffering and misery, they in reality accomplished very little except to possibly improve the American image."[75] Colonel Jenkins goes on to say that it is yet to be determined if the people perceive their own military in a more positive light.

An integral component of evaluation is a viable quality assurance program. In the US quality assurance is driven in no small part by fear of legal action in the form of malpractice suits. The legal incentive to provide quality care is not as prevalent during MEDRETES nor is there the need for the tremendous bureaucracy that has developed to insure quality care. However, the moral and ethical obligation still exists for the military to provide an appropriate standard of care during MEDRETES. Yet quality assurance is apt to fall victim when the number of bodies seen is used as the primary evaluation criteria.

People waiting hours in line learn what symptoms to describe in order to obtain medication to stockpile in their home or to sell on the black market.[76] Questions regarding quality of care must be asked when health care providers must do histories (through an interpreter), evaluate, diagnose and treat hundreds of patients in the course of a day's MEDRETE.

The cost benefit ratio of MEDRETES has not yet been established in an objective manner. The direct costs are high. Approximate MEDRETE costs include: $14,000 for two TEAMS members, $159,000 to $397,000 for a forty five member cell for two weeks, $25,000 for incidentals (i.e., in country travel), and $36,000 for medical supplies.[77] This represents a considerable investment, especially considering that TEAMS runs about two MEDRETES each month. Without quantifying the benefit of the program, it is difficult to justify the expense. There are some ARNG decision makers who question the overall value of the program. There is no tangible residual from the program (it is much easier to justify a program where there is a building or road that people can point to as an accomplishment). With no proof of long term impact, there is a move to change the program to a more prevention based program. Colonel Weisser, former commander of the US Army medical element in Honduras, advocates the transition from MEDRETES to Preventive Medicine Readiness Training Exercises as a program that would produce a higher payoff in terms of impacting on the

health of the nation.[78] Yet this type of program would be even more translator dependent and the hands on medical training would be largely lost. There is also sentiment to move the program out of SOUTHCOM, where there is no indication that the host nation governments or agencies have institutionalized the program or attempted to make it their own. As such, the MEDRETE program is like a finger in a bucket of water. As soon as the finger is removed there is no indication that it was ever there. To remedy this, a recommendation has surfaced to put the responsibility of planning and running MEDRETES on the host nation with the US military assisting.

History of ARNG in MEDRETES in SOUTHCOM

In the spring of 1986, the Chief of the National Guard Bureau, Lieutenant General Temple, escorted a group of about 20 VIPs, to include educators, business people, and media personnel on a tour of the CINC's area of responsibility in SOUTHCOM.[79] His purpose was to help dispel rumors that the US was going to invade.[80] In Panama they received a briefing from the SOUTHCOM staff. The briefing, given by the United States Army South's (USARSO) and CINC's staff, included information about MEDRETES being run in conjunction with the ongoing Blacklight exercises.[81] General Noriega's units were providing health care to the people of Panama and were gaining popularity.[82] A proposal was presented to Lieutenant General Temple that the MEDRETES

could be done by ARNG personnel and units and in fact that CINC SOUTHCOM needed personnel resources that the ARNG could provide. He immediately set about to determine the resources it might require and how it might be accomplished.[83] It is logical to assume that Lieutenant General Temple was aware of the positive training opportunities presented by this proposal. At least four ARNG medical units had been on medical civic action activities in conjunction with the medical element at JTF-B in the preceding year.

Lieutenant General Temple directed the establishment of an ARNG field medical training site in Panama. He assigned two ARNG staff officers, one Medical Service Corps and one Engineer, to make it happen. The Medical Service Corps officer established the mission, organization, and job descriptions.[84] The Engineer officer was tasked to coordinate with USARSO to find a site at Fort Kobbe for the physical structure to house the organization along with its equipment. Three bunkers that had not been used since World War I were dedicated to the project. The bunkers were rehabilitated by ARNG engineer units as part of their annual training. The area was fenced, utilities were put in, and a parking lot was installed. In the compound's finished state, the first bunker housed the motor pool and a storage area, the second bunker housed the medical supplies (with adequate security measures in place to accommodate

controlled substances), and the third bunker was used for administration and unit supply.[85] The ARNG sent a clearing company medical set for the original FMTS equipment. (The set was put on the books of the District of Columbia ARNG as NGB cannot own equipment.)[86]

On the organization side it was necessary to consider how the funding would flow from NGB to the FMTS, who would have UCMJ authority over assigned personnel, command and control, as well as other administrative matters to be resolved before a new organization could be stood up. An early problem encountered was that Gorgas Hospital was hesitant to provide drugs and other medical supplies. Another problem was obtaining the equipment to run the MEDRETES. At the time these issues were being resolved, there was a senior ARNG advisor (non-medical) stationed at USARSO and a senior ARNG medical liaison at the SOUTHCOM surgeon's office. The original plan was to put the FMTS under the senior ARNG advisor, but this proved to be too unwieldy.[87] The solution was to incorporate the FMTS as an element of the 142nd Medical Battalion (an active duty unit). This organization proved to be very successful and lent the legitimacy that Gorgas hospital required to fill requisitions for medical supplies and pharmaceuticals.

Initially an interim FMTS commander was assigned, because the officer selected for command was not immediately available to assume the position. It is interesting to note

that the interim commander was a medical logistician with active duty experience with the medical element at JTF-B in Honduras. The commander who followed him had extensive experience as a member of an ARNG evacuation hospital. Therefore, the first two commanders were uniquely qualified for the position and the FMTS enjoyed a high degree of success during their tenure. The subsequent commander, while he had previous military medical experience, was not branched in an Army Medical Department (AMEDD). As a result he did not have the same level of credibility with the medical community. This may have proved a hindrance in accomplishing the mission, especially considering the successes of the previous two commanders.[88]

The FMTS conducted its first ARNG MEDRETE in March 1987. It was done in Panama in conjunction with a Blacklight exercise where roads were built and schools erected. The MEDRETE was evaluated and plans revised and improved in preparation for the next one scheduled for August 1987. However, one month before the second MEDRETE the State Department, in response to increased tensions between the US and Panama, ceased all military to military contact in Panama. All efforts at the FMTS came to a halt. In order to salvage the work and resources that had been invested, the FMTS decided to pursue MEDRETE opportunities outside of Panama. Working in conjunction with the senior ARNG liaison at the SOUTHCOM Surgeon's office, the FMTS was

directed to look at Costa Rica, Guatemala, Honduras, Bolivia, and Ecuador for potential MEDRETE sites.[89] This change put a tremendous strain on FMTS personnel. The organization had been planned and staffed to conduct MEDRETES in Panama. It quickly transitioned to doing MEDRETES throughout Central and South America. With only one officer, the NCO's were given an enormous amount of responsibility to accomplish coordination with host nations and to facilitate the successful execution of units' missions. The FMTS staff was in a travel status almost continuously.[90]

Personnel from the FMTS and the SOUTHCOM Surgeon's office traveled to these five countries and presented the concept to the Ambassador. Also in attendance at these meetings were personnel from AID and the Peace Corps. The program would only be implemented if both the President and the military of the host nation agreed. Upon approval from the Ambassador, the MILGPS established contacts with the country's military while the FMTS personnel coordinated with the ministry of health. As a result of this effort, Bolivia requested a MEDRETE every three months; Costa Rica asked for one per year; two were scheduled in Honduras (out of JTF-B); and Ecuador requested only one. From 1987 to 1989, the FMTS ran MEDRETES at the rate of one to two per month.[91] In addition, the SOUTHCOM Surgeon was running about the same number with active duty medical units.

The original full-time staff at the FMTS was fairly robust, with twelve people authorized and ten assigned. Considering that the entire ARNG Title X work force was only about 1300 people,[92] this demonstrated a very strong commitment to the program on the part of the National Guard Bureau leadership.

Table 1.--Original Personnel Authorizations for FMTS

Position	Grade	Quantity
Commander	O-4	1
Training NCO (91 series)	E-8	1
Medical Operations NCO (91B)	E-7	1
Medical NCO (91C)	E-7	1
Medical Specialists (91B)	E-7	2
Unit Supply NCO (76J)	E-7	1
Administrative NCO (71L)	E-6	1
Bio-medical repair (35G/U)	E-5	1
Motor Sergeants (63B)	E-6, E-5	2
Power Generation Mechanic(52D)	E-5	1

Source: Lieutenant Colonel Roger Healy, (Former Commander, FMTS)

The primary functions of the staff were to maintain the equipment and support the ARNG medical units in the performance of their training. The FMTS personnel also acted as liaison between the ARNG unit and all other

personnel and agencies involved in the MEDRETE, to include SOUTHCOM and USARSO personnel and local government and embassy personnel. The commander had a clear vision for the FMTS and was instrumental in building the program. He went so far as to design a guidon for the unit and have it approved by the Department of Heraldry.

The original FMTS staff was often put in a position of being innovative in accomplishing their mission. This had as much to do with standing up a new unit as it was due to the nature of the times. The fact that after only one mission the focus of the FMTS changed from training in Panama to training outside of Panama put a significant strain on the organization. Additionally, the staff was expected to accomplish missions given directly to them by ARNG personnel at United States Army South (USARSO), even though organizationally they fell under the medical battalion. This created some friction. For instance, the FMTS was supposed to go through the medical battalion for supplies and other logistical support. Yet the medical battalion was unable to turn around requests for support as rapidly as the FMTS was tasked to do missions. The FMTS commander remedied this situation by setting up direct accounts and bypassing the medical battalion. This contributed to the success of the FMTS in accomplishing their missions, but did not facilitate good organizational relationships.[93]

In preparation for a MEDRETE, the FMTS staff would arrange to preposition the medical equipment with the MILGP in the country in which the MEDRETE was to occur. The equipment consisted of all equipment and supplies necessary to conduct the MEDRETE tailored to the specific community. At a minimum it included trucks, radios, tents, cots, and medical supplies. The unit's only responsibility was to bring the requisite number of properly credentialed health care professionals and appropriate support personnel. (This could be considered a drawback of the training benefit in that units do not have to pack and transport organic equipment.)

Originally the FMTS was authorized a medical equipment set from a clearing station as well as a dental set. The equipment as such was not appropriate for the types of missions the FMTS was conducting. For instance, the dental set was configured for general dentistry, but the missions often entailed pulling teeth rather than restoration of teeth. The staff effectively tailored the sets to meet mission needs. Also, the original equipment packages were not configured to deal with trauma cases. However, after an incident in Guatemala in 1988 (host nation soldiers had been shot and were evacuated to a MEDRETE site for treatment), the FMTS staff established a trauma set to include on missions.[94]

Normally the unit would arrive in Panama, be met by the FMTS staff who would brief them on the mission and security considerations. They would then escort them to the area where the MEDRETE was to occur, after stopping at the MILGP to pick up the equipment. The FMTS training Non-Commissioned Officers would remain with the unit while the FMTS commander would return to the capital to meet the advance party of the unit scheduled to do a MEDRETE in 3-8 months. He would accompany them to the ongoing MEDRETE so they would know what a MEDRETE looked like. He would then accompany them to the country and village where their MEDRETE was scheduled in order to accomplish the required site survey.[95]

The mechanism for a unit to participate in a MEDRETE is usually through Forces Command (FORSCOM). All the combatant CINCs submit a list of missions for which they require units to participate. The FORSCOM consolidates all the request for army participation in joint training and pure Army requests and broadcasts them to major commands. FORSCOM holds an annual overseas deployment training (ODT) conference. Training personnel from interested organizations, such as NGB, can sign up units to participate in these training opportunities. The FORSCOM would then document, in writing, all units authorized to participate in overseas deployment training (ODT). If the unit was not on FORSCOM's list, it would not be eligible for ODT training.

However, a CINC could shortcut this process by holding their own ODT conference prior to the FORSCOM conference. The SOUTHCOM used to do this, and NGB would attend and sign units up for training. This gave ARNG units an advantage in that the CINC would submit a shorter list of open opportunities to FORSCOM. This was particularly true for medical training opportunities in that the ARNG had people on the ground in both the FMTS and at the SOUTHCOM surgeon's office who were very interested in increasing training opportunities for ARNG medical units.[96]

The ARNG units on a MEDRETE would be in an annual training (AT) status. The NGB, through the State, would be responsible for all training expenses for a unit on AT in CONUS. Costs for a unit on AT OCONUS would be split. The NGB, through the State, would be responsible for all personnel and operating costs from home station to the training location. All other expenses were borne by SOUTHCOM. The definition of the training site differed between the SOUTHCOM staff and some of the State training managers. Some States balked at paying for a unit all the way to the MEDRETE site and would pay for the unit to travel only as far as Panama. The FMTS staff on occasion could remedy this by having the unit bypass Panama and traveling straight to the training site.[97] On other occasions the State would utilize their Air National Guard assets to fly the unit directly to the site.

Units are not always able to fill all the positions required to conduct a MEDRETE. The State headquarters of the ARNG involved may have committed a unit to perform a MEDRETE in the following training year. Nearer the time of exercise they may discover they cannot fill all the slots with personnel of the requisite specialty. (Physicians schedules can be fickle and many state ARNG's do not have large numbers of physicians to canvass to fill the requirements.) When this situation occurs the State headquarters contacts the operations directorate at NGB. The NGB acts as a clearing house by putting out a message to all State headquarters announcing open mission requirements. State headquarters able to fill the position are directed by NGB to coordinate directly with the sponsoring state. The NGB has effectively refined this clearing house function to insure that all ARNG MEDRETES are appropriately manned.[98]

While not formally measured, the success of the FMTS's work can be summed up through anecdotes. The AID personnel in Guatemala jokingly complained that the ARNG were responsible for expending all their printing funds. The fact is that AID was pleased to have access to the manpower able to distribute educational material and rehydration packets to appropriate target populations throughout the country.[99] On several occasions, when submitting requests to the SOUTHCOM Surgeon's office for units to do MEDRETES, the MILGP personnel would specifically

ask for ARNG personnel as opposed to active duty personnel.[100] They perceived that ARNG personnel were more sensitive and kinder to the people. Also, medical units participating in MEDRETES claim that their retention and recruiting efforts have been enhanced by offering this training opportunity.

The benefit of MEDRETES to the host country is not just to provide health care in a community but also to demonstrate a positive military image as well as to have professional contact with practitioners in the involved country. For each health clinician the US provided, the involved country was to agree to provide an equivalent counterpart. However, this did not always work out, especially given that there is generally no Latin American equivalent to a physician assistant (which is a very common health care provider in the US Army and particularly in the ARNG). Additionally, the involved country would normally provide translators. This was especially critical when the MEDRETE was conducted in a village where the primary language was an Indian dialect. In most cases, the unit conducting the MEDRETE would bring along some translators. It was not uncommon for ARNG units to spend six to eight months prior to AT learning rudimentary and medical Spanish.[101]

The MEDRETES were not totally secure operations. The host nation would provide security personnel who would sweep

the village and set up a perimeter defense before the US unit came in. The ARNG units had the occasion to treat soldiers with bullet wounds during MEDRETES (something they were unlikely to have the opportunity to do on annual training in the continental US). On occasion the security personnel would tell the unit that the site was no longer secure and direct them to leave for their own safety. This gave the units experiences beyond what one would normally define as training for OOTW. This experience is better defined as participating in OOTW. While the ARNG did not knowingly participate in any intelligence activities or carry along any intelligence personnel with them, they were debriefed upon their return.[102] One might conclude that there was some intelligence benefit from these debriefings. There were some instances where, after a MEDRETE was ongoing for several days, and the community was accustomed to having soldiers in their community, other soldiers would show up and erect radar sites in the community.[103] The appearances were that they were using a MEDRETE to screen other military activities, such as counter drug operations.

The ARNG leadership recognized the success of the FMTS and in 1990 began to consider creating a similar structure in Panama to support engineering exercises. The ARNG had been participating in Engineering Readiness Training Exercises (ENRETES) for some time. These exercises were conducted for many of the same reasons as MEDRETES but

the results were easier to measure in that the product was a road or a building. Additionally, in 1991 the USAR was attempting to create its own FMTS. While they had the personnel to accomplish the mission they did not have a stand alone operation as they lacked buildings and equipment. In the interest of teamwork and efficiency the ARNG engineers and both the ARNG and USAR FMTSs combined into an organization called the Theater Equipment and Maintenance Site (TEAMS). Teams was activated in October 1991.

The additional infrastructure of TEAMS was set up within blocks of the original FMTS, which remained in its old location. The staffing of the FMTS changed to make modular teams which would support the MEDRETES. A team consisted of three people, a medical service corps captain, a master sergeant with a medical military occupational specialty, and a medical supply sergeant. Originally under TEAMS there were four such teams, two ARNG and two USAR. Also, on the medical side of TEAMS was a Medical Service Corps major who served as operations officer and oversaw the entire operation. A medical supply NCO and biomedical equipment repair person also worked on the medical side of TEAMS. All administrative and general maintenance functions were provided by personnel who supported both the medical and engineering functions of TEAMS. Additionally, the ARNG attempts to keep liaison personnel at up to four MILGPs

where the ARNG is heavily involved in training exercises. These liaison personnel are ARNG soldiers on short tours of up to 179 days.[104]

The process for planning and conducting MEDRETES has not changed significantly under the TEAMS organization. The host nation submits requests to the country team at the US embassy. The MILGP submits these requests, prioritized by location and date, at a SOUTHCOM sponsored deployment for training conference. (These requests do not include medical civic action done in conjunction with engineering exercises.) SOUTHCOM consolidates and prioritizes the requests and publishes a list of training requirements at least one year out. The list includes the dates of the actual MEDRETE as well as the dates of the leaders reconnaissance and advance party requirements. (The site survey is typically done six months prior to the MEDRETE and the advance party, which consists of six people from the participating unit, is expected to be in country five to six days before the main body.) The TEAMS usually sends one officer and one NCO to accompany the advance party (round the clock communication support is provided on site by active component personnel). Medical supplies are shipped prior to the arrival of the advance party. The leader's reconnaissance personnel would have accomplished the assessment to determine the types of supplies necessary, (i.e., they estimate the number of dogs in the targeted

community to determine the correct amount of rabies vaccine). Personnel from the advance party and representatives from the MILGP meet with appropriate host nation agencies to finalize any details of the MEDRETE. The base camp is established when the main body arrives on site. The actual MEDRETE lasts about nine days after which a closing ceremony is conducted.[105]

Participants on the leaders reconnaissance are not always able to accomplish the mission they are assigned. They may coordinate at national or regional level for a MEDRETE which is to be conducted at the local level. As a result sometimes they find the planning information they are given is not applicable. The local community may be unaware that a MEDRETE is planned, or they may have very different expectations as to what the outcome of the MEDRETE should be. This occurs when the national governments possess or define different priorities than the target population. This may be caused by lack of communication or different perspectives, but it leads to a frustrating experience for all involved, especially when the participating unit is ill prepared to meet the perceived needs of the community.[106]

To the customer the transition from the FMTS to TEAMS was transparent. However, the realignment reduced redundancy in administrative and maintenance functions. More importantly it reduced the extreme workload on the staff and shifted some of the responsibility from the NCOs

to commissioned officers. Surprisingly, in the Fall of 1993, the USAR split from the TEAMS organization and moved to Corozal Heights to support USAR MEDRETES. The TEAMS commander still has the responsibility to provide support to the USAR FMTS. Indications point to the fact that the split may have occurred more as a result of philosophical and personal differences rather than for mission needs. The impact the split will have on the MEDRETE program has not been fully assessed but, the fact that Corozal Heights is at a greater distance from the airfield has caused some question as to the wisdom of splitting from TEAMS.

Colonel Nevin, the senior ARNG advisor at USARSO, believes that the TEAMS concept, while requiring some adjustment, is very stable. The organization is not perfect in terms of MOSs and positions authorized. He has justified 31 ARNG full-time positions but only 22 are filled. He has managed to make up some of the shortfall by augmenting the organization with personnel on an annual training (AT) status or in an active duty for special work (ADSW) status. Currently the Alabama National Guard (167th COSCOM) is putting a 50 soldier rotation through USARSO every two weeks, (30 go to support TEAMS). These soldiers primarily provide maintenance and repair parts support to the engineers, but some actually work at the hospital.[107]

TEAMS has become one of the focal points for how the US will do business in SOUTHCOM until the end of the

century. It also has become central to USARSO. As the active duty Army continues to draw down in Panama, TEAMS' contribution will become proportionately larger.

Continued Support Of MEDRETES by ARNG

The fact that the ARNG was the first of the reserve components to get involved in MEDRETES is worth examining. It is essential to examine the structure and culture of the ARNG in order to determine the reasons individuals in the ARNG were able to pursue and implement this valuable training opportunity in such an expedient fashion.

Logic would seem to dictate that the United States Army Reserve (USAR) would have a greater vested interest in the training of medics since the bulk of the Army medical units are in the Army Reserve. (In 1992 there were 23,704 medical positions in the ARNG and 43,974 in the USAR).[108] Yet it was the ARNG that first developed the concept of an infrastructure to support training of medics in SOUTHCOM.

It was the ARNG which devoted significant resources to build that infrastructure. This is not to say that the USAR did not recognize the value of the FMTS. The senior medical advisor (active component) to the USAR was a supporter of the ARNG. He followed the development of the FMTS and decided to use it as a model for the USAR program. In fact the USAR had an officer (Major Montalto) working in the medical operations at the US Army South surgeon's office beginning in December 1986. His impression was that the

ARNG had an advantage with the Key Personnel Upgrade Program (KPUP). This program allowed the ARNG to send individuals to train with active component units in order to improve their skills and competencies as a key member of their home unit (usually as a leader). Major Montalto also noted that the ARNG was able to get people to SOUTHCOM faster whereas the USAR always had to go through Forces Command. While he perceived that the ARNG were able to work the system to their advantage, he also noted that the ARNG used the system to assist the USAR obtain necessary assets. During this time period the USAR and ARNG SOUTHCOM medical staffs seemed to work well together in a mutually supportive fashion.[109] After the USAR initially considered building a parallel structure, they eventually decided the best course of action was be to integrate the staffs.[110]

Given that the ARNG is primarily combat arms units (21 hospitals which are battalion level commands compared to eight divisions and ten separate brigades[111]), it is logical that the organization would assume a culture where the combat arms would be given deferential treatment. Despite that, a highly successful medical training program was implemented and still enjoys success. This apparent anomaly deserves analysis.

It appears the structure or the ARNG is one where an individual can have a significant impact on the organization. The average end strength for a State is about

12,000 soldiers. There is a strong sense of identity to the State organization. Most States have a private ARNG association which acts to promote the sense of belonging. There is also a national association (National Guard Association of the United States). These organizations actively support the ARNG in each State and territory and serve as a voice and advocate for National Guard unique issues in state and national political bodies. In addition, the ARNG has a very powerful political voice in the office of the governor, who is also the commander of his or her National Guard. Overall, this culture allows for and encourages action for change and advancement of Guard issues. This is the environment where the initial reserve component involvement in MEDRETES was born.

Several individuals in the ARNG, who recognized the need for medical training, also saw a tremendous opportunity for that training in SOUTHCOM. They were working in an environment that supported initiative. Within a period of one year the original MEDRETE idea was developed, resourced and implemented. By contrast, the USAR is an organization that has been defined as having significantly more bureaucracy than the ARNG. (Army Commands or ARCOMs are in the USAR chain of command. Some have described these organizations as nothing more than an additional layer of bureaucracy designed to obtain general officer billets.) As a result, it is harder to implement change in the USAR.

Also, the ARNG has more control over its own budget which allows greater flexibility in program planning and execution.

The ARNG is a almost a purely table of organization and equipment (TOE) or field force. The only table of distribution and allowances (TDA) structures are the national and state headquarters at NGB and State Area Command (STARC) level. These TDA structures represent a very low percentage of the total force. Here again the TOE culture of the ARNG could be considered to have had an influence on the initiation of the MEDRETE program. While the USAR has a significant TOE medical force, it also has a considerable medical TDA force structure. Hence, their perspective on training might be different. The ARNG's total orientation is to train in a field environment. As a result, the prospect of training in an austere field environment was very attractive. It may have been less of a paradigm shift for the ARNG to train their medical units in a field environment than it was for the USAR. On the other hand the USAR might garner more benefit from conducting much of its medical training in fixed medical facilities.

Today, the ARNG medical community faces severe challenges to maintaining the MEDRETE program. The Army's reserve components are realigning themselves to increase the percentage of combat service support units in the USAR and increase the percentage of combat arms units in the ARNG.

(The USAR will become 100% combat support (CS) and combat service support (CSS) units with thirty two percent of the Army's CS and CSS support. The ARNG will provide thirty one percent of that support while maintaining approximately 40 combat maneuver brigades.)[112] The end result will mean that the ARNG will transfer most of its medical units to USAR. Also, as a result of the downsizing, the full-time active guard and reserve force (AGR) will also be reduced. A logical outcome of these two changes would mean that medical operations will become even lower in priority and the infrastructure built in Panama to support MEDRETES might no longer be staffed. If there are no medical units left to take advantage of the training opportunities, it makes no sense to expend resources. However, this fact ignores the embedded medical personnel in the combat units (i.e., brigade and battalion surgeons and combat medics in the medical platoons and forward/main support medical companies).

The outcome of the realignment between the reserve components is in its infant stages. While the ARNG still has a significant medical investment in SOUTHCOM, there have been well reasoned arguments to reduce that support. The USAR currently has invested resources in support of the SOUTHCOM MEDRETE program. If the ARNG reduces its support, the USAR would logically provide the services. It would be interesting for this to occur because the ARNG originally

provided support to the USAR, then the programs were integrated for a time. We may see the circle closed if it happens that the USAR picks up the mission of providing all training support to reserve component medical units in SOUTHCOM.

CHAPTER 5

CONCLUSIONS

If one thinks of a spectrum of nation assistance efforts, it might have disaster relief on one end and long-term development on the other end. While it is apparent that MEDRETES would fall on the spectrum, the purpose of each individual MEDRETE would determine where it would fall on that continuum. As the MEDRETE program has matured, the different organizations and individuals involved have had different concepts of the purpose of MEDRETES. The reality has been that MEDRETES have fallen all along the spectrum. The CINC assigns MEDRETES to a location with an eye toward establishing a more stable nation, which implies long-term development. Yet MEDRETE locations have been changed just prior to implementation to help with an unexpected catastrophe. For instance, after a huge landslide in 1993, the government of Ecuador requested aid. A MEDRETE was quickly diverted to the landslide area to provide disaster assistance.[113] (In order to counter a negative reaction at the original MEDRETE location an extensive public affairs campaign was implemented. The people were made aware of the reasons for the delay of their MEDRETE and assured that one would be forthcoming in their village.) The military's

involvement in the disaster relief end of the spectrum has become almost expected by the American people and by the government. The Department of Defense has embraced this role as they have unique resources and capabilities which are well suited to these missions. In addition, in these days of declining resources, disaster relief activities help justify end strength and equipment while remaining popular with the American public. For the same reasons the Department of Defense is paying more attention to the other end of the nation assistance spectrum. The military has the potential to play a much larger role in long term development as it applies to nation assistance.

The ARNG's involvement in MEDRETES as a form of nation assistance has followed what seems to be a natural evolution. The birth of reserve component involvement in MEDRETES began primarily with the ARNG recognizing a valuable training opportunity and devoting resources to realize that opportunity. (It is important to note that the commitment to the MEDRETE program occurred at the same time as the ARNG devoted more resources to medical recruiting. The ARNG was significantly short of physicians and other health care clinicians. Throughout the 1980's, NGB set up a medical recruiting program with dedicated recruiters in most of the States and territories. Prior to this, clinicians were recruited by the regular recruiting staff.) This

demonstrated an overall commitment to an improved medical readiness status throughout the ARNG.

As the program matured and the value was validated, other components began to devote resources to glean the same training benefit. Today the program is well entrenched in SOUTHCOM's overall plan of programs. As the program continues into another decade, we see the ARNG's role as a lead player has not been diminished. Yet the reduction in ARNG medical force structure puts the future of the program as we know it at risk. History, however, demonstrates that there will always be a medical component to the ARNG, and those personnel will need to remain trained. History also demonstrates that the ARNG has applied innovative solutions to problems. The culture of the ARNG is one where the job gets done. It might not be done by the book, but the end product is the same. This culture allows and encourages creative thinking and individual effort. As a result it is not uncommon for individuals with a good idea to see that idea to fruition. Some might consider this to be a personality driven organization and thus attach a negative value, but in fact it is an organization structured to prosper.

While there are many theoretical problems associated with the conduct of MEDRETES, few of them seem to exist in actuality. The feedback from the people participating in the planning and execution of the MEDRETES is universally

positive. The units participating in the training consider the experience to be outstanding. In the absence of any negative outcomes, this training benefit alone is sufficient to continue to support and resource the program. There is no doubt that MEDRETES provide some of the best training that a medical unit can experience. In addition, the incidental benefits are significant to a number of the players. The recipients of the health care reap the most significant benefit. During an interview, the Chief Surgeon of the National Guard Bureau was questioned about the long term value of host country children getting physical exams and de-worming medication during MEDRETES. He stated the case as: "Some people would argue these exams are not very worthwhile because six months later the kids will have the parasite back again, but pediatricians say that those six months that the infant might have grown and put on enough weight where they're healthy enough to handle parasites. If you didn't get rid of the parasites in those six months it would lead to a lethal infestation."[114]

The Ambassador's team also derives benefit from the MEDRETES. It seems that most often MEDRETES are very well received by both the national governments and the communities where the exercises occur. The MEDRETES help foster positive relations between the host country population and the US military. They also give the host country military an opportunity to be seen in the same

positive light as a result of their participation in MEDRETES. This helps the country team immeasurably in their security assistance endeavors. Lastly, the SOUTHCOM CINC is an advocate of MEDRETES as part of his plan to help strengthen fragile democracies.

The MEDRETE program (along with the parallel engineer readiness training exercise program) has proven to be a valuable model for actual reserve component involvement in OOTW. Units are able to obtain training while contributing to real world missions. As the Army continues to be drawn down, the need for US forces to accomplish missions is continuing. What used to be uncommon, reserve component forces be counted on to do real world missions, is becoming fairly commonplace. For instance, Air National Guard and Air Force Reserve units have been flying most of the relief missions over the former Yugoslavia.[115] The trend to involve the reserve components in real world missions demonstrates the competencies of reserve forces and gives the nation a more immediate return on the investment made in the reserves.

The reserve components are well suited for nation assistance and civic action. The ARNG in particular has an edge in that many of these missions mirror their traditional state mission of providing assistance during times of domestic disaster and civil disturbance. Also, it has become apparent that these types of missions can be worked

over the long term with a small, informed full time cadre. The regular work force can accomplish the mission in short intervals. This system meshes nicely with the reserve components training cycle of two days per month and two weeks per year.

Recommendations

Given the amount of resources that we as a nation expend on assistance to other countries, and given the fact that we as a nation are clamoring for a reduced budget, we need to look very closely at how we expend resources. The President determines our National Security Strategy which outlines our National objectives in dealing with other countries and regions. All US governmental agencies working in foreign areas should use this document as the start point for determining their own organizational vision, goals, objectives and programs. It is incumbent upon these agencies that they work in concert with one another in order to accomplish their mission in as an efficient a manner as possible. To this end, there is a definite overlap between AID and the CINC in accomplishing national security goals in South and Central America, particularly in the arena of medical care.

The AID and the military should work more closely, and statutes should be carefully amended to insure a more productive working relationship without causing conflict of interest. The AID should incorporate MEDRETES into their

long-range development plans and programs, and the military should attempt to look at long term objectives when implementing the MEDRETE program. This can be done without degrading the training benefits derived from MEDRETES. For instance, continuity of care is considered critical to have any lasting impact on an individual's health. Yet currently there is little consideration for units to go back to the same villages for MEDRETES. This could be done without diminishing the other benefits derived from MEDRETES.

The host nation should be more involved in the planning and execution of the MEDRETES. Currently the program is fueled by US forces. This insures that the US military controls the program and therefore can manipulate it to meet stated internal needs. However, there is little evidence to indicate that the program would continue without the US military to back it. An admirable and achievable goal to work toward would be to facilitate host nations ability to institutionalize the program as they see fit.

Programs that cannot be objectively shown to be of benefit are at risk in today's Army. Yet very little objective evidence exists to show that MEDRETES accomplish any of the objectives they are meant to achieve. While they receive universal acclaim at all levels, there is a real need to measure their success. Programs must be evaluated and adjusted in order to reach their maximum potential and to continue to meet changing needs. While there is abundant

anecdotal evidence that MEDRETES is a valued program, when it comes down to dollars and cents, objective data is needed to continue to justify the program, especially in these days of diminishing resources.

With that said, there is still enough to indicate that the ARNG should remain involved in the program. The ARNG has proved to be innovative and flexible in its approach to the program. The training opportunities are sufficient to justify ARNG medical unit involvement. While the ARNG may be losing most of its medical unique force structure, there is still significant medical force structure embedded in the combat units. The same reasons exist to insure those units get good training as existed for the purely medical units.

By virtue of the fact the US is committed to leaving Panama by the end of the century, the ARNG must look to what their role will be. Questions need to be answered, such as: Will the ARNG revert to a more domestically based organization by expanding its State mission? It is likely that states will be forced to become less dependent on federal dollars. In this event governors will look more and more to resources they control. The National Guard is one such resource and most governors place a high value on their ARNG resources. It is also likely that the ARNG be expected to take on a larger role in the international arena as the total force draws down. As such the ARNG may want to

attempt to leave some semblance of a structure in Central or South America to continue the MEDRETE mission. Assumptions must be made and goals set so that the transition in 1999, out of Panama, goes smoothly, and US advancements in the region are not sacrificed.

This study has examined the involvement of the ARNG in MEDRETES at the macro level and in a somewhat superficial manner. There is much yet to be studied. A recruiting and retention study should be accomplished to see if the MEDRETE experience has had any impact on health care professionals attitude and behavior in regards to joining and remaining in the ARNG. The entire future of the MEDRETE program needs to be assessed to determine if the US military should continue in generally the same vein. It may be time to make some major changes in the program, such as turning it into a preventive medicine oriented program, turning it over to the host nation, or even stopping the program. Additionally, it is likely that there is a wealth of information in the after action reports filed at USARSO. An extensive study of these reports in addition to a study at the participating units' level would benefit the academic world and may reveal valuable clues as to how to modify the program.

The goals and objectives of the MEDRETE program must be clearly established at every level, and all involved must have a clear understanding of their role. Criteria needs to be established with which to evaluate the program. Short-

term goals must be reconciled with long term goals in order to reduce participants' frustrations and misunderstandings. The MEDRETES alone will not insure the health of any nation. The ARNG, as a major player in SOUTHCOM MEDRETES, must be intimately involved in planning the future of the MEDRETE program.

ENDNOTES

Chapter 1

1. Headquarters, Department of the Army, Field Manual 100-5, Operations, (Washington, D.C.: US Government Printing Office, 14 June 1993), 13-5 through 13-8.

2. ElRay Jenkins, Medical Civic Action Programs and Medical Readiness Exercises as Instruments of Foreign Policy, Army War College Study Project, Carlisle Barracks, 23 May 1988.

3. Anonymous, "US Medical Teams Serving remote areas of Latin America," Honduras this Week, 13 March 1993, 13.

4. William Matthews, "Guard Troops Used to Fight Urban, Rural Ills," Army Times, 28 June 1993, 22.

5. George A. Joulwan, Commander in Chief, US Southern Command, Statement presented before the Senate Armed Services Committee, Washington, D.C., 21 April 1993.

6. Philip A. Brehm, Restructuring the Army: The Road to a Total Force, Strategic Studies Institute, US Army War College, (Carlisle Barracks, PA, 1992), 3.

7. William Matthews, "Ready to Go Units Aim for a Greater Role," Army Times, August 16, 1993, 26.

8. Harry Noyes, "US Medics Serve U.N. in Croatia," HSC Mercury, Vol 20 No. 11 (August 1993): 9.

9. Harry G. Summers, On Strategy, A Critical Analysis of the Vietnam War, Novato, California: Presidio Press, 1982, 36-37.

Chapter 2

10. Dan Bradford, "Panama's Fort Kobbe Houses Medical POMCUS," National Guard, Vol XLI #11 (November 1987): 34.

11. "US Medical Teams serving Remote Rural Areas of Latin America," Honduras This Week, (13 March 1993): 13.

12. HQ US Army South, Memorandum of Instruction, Medical Readiness Training Exercises/Medical Civic Action, (Ft Clayton, Panama, Jan 92), App B.

13. William E. Carter III, "Planning for a Medical Readiness Training Exercise," Army Logistician, (May-June 1994), 35-37.

14. Bernard E. Harvey, US Military Civic Action in Honduras 1982-1985: Tactical Success, Strategic Uncertainty Army-Air Force Center for Low Intensity Conflict (Langley Air Force Base, Virginia, 1988).

15. John D. Depauw and George A. Luz, Winning the Peace: The Strategic Implications of Military Civic Action, Strategic Studies Institute, US Army War College, (Carlisle Barracks, Pennsylvania, 1990).

16. Robert G. Claypool, Military Medicine as an Instrument of Power: An Overview and Assessment, Study Project, US Army War College, (Carlisle Barracks, Pennsylvania, 1989).

17. ElRay Jenkins, Medical Civic Action Programs (MEDCAPS) and Medical Readiness Training Exercises (MEDRETES) as Instruments of Foreign Policy, Study Project (Carlisle Barracks, Pennsylvania, 1988).

18. Russ Zajtchuk, William Brown and James Rumbaugh, "Medical Success in El Salvador," Military Medicine 154 (February 1989).

19. James A. Taylor, "Military Medicine's Role in low Intensity Conflict," Military Review (April 1985).

20. Thomas Sewell, U.S. Reserve Component Training in US Southern Command--An Example of Total Army Concept," Study Project, (Carlisle Barracks, Pennsylvania, 1988).

21. Charles Heller, The New Military Strategy and its Impact on the Reserve Components, Strategic Studies Institute, (Carlisle Barracks, Pennsylvania, 1991).

22. Sam Nunn, Domestic Missions for the Armed Forces, Strategic Studies Institute, (Carlisle Barracks, Pennsylvania, 1993).

23. Brian Ohlinger, Peacetime Engagement: A Search for Relevance?, Strategic Studies Institute (Carlisle Barracks, Pennsylvania, 1992).

24. Philip A. Brehm and Wilbur E. Gray, Alternative Missions for the Army, Strategic Studies Institute (Carlisle Barracks, Pennsylvania, 1992).

Chapter 4

25. Headquarters, Department of the Army, Field Manual 8-10, Health Services Support in a Theater of Operations, (Washington, D.C.: US Government Printing Office, 1 March 1991), 1-8.

26. Ibid., 3-8 and 3-9.

27. Headquarters, Department of the Army, Army Regulation 40-1, Composition, Mission, and Functions of the Army Medical Department, (Washington, D.C. :US Government Printing Office, 1 July 1983), 1-1.

28. Robert Claypool, COL, "Military Medicine as an Instrument of Power," 30.

29. Ibid., 2.

30. Ibid., 3.

31. Ibid., 9-12.

32. Ibid., 21-24.

33. Harry Noyes, "US Medics Serve U.N. in Croatia," HSC Mercury 20 no. 12, (August 1993): 9.

34. COL Claypool has been Chief of the Medical Corps, Chief of the Surgeon General's Consultants, Commander of Brooke Army Medical Center and was recently promoted to Brigadier General. It is reasonable to expect that his opinions would carry a great deal of weight in the Army medical community.

35. Claypool, 32.

36. Jeffrey Greenhut, "Medical Civic Action in Low Intensity Conflict: The Vietnam Experience," Winning the Peace: The Strategic Implications of Military Civic Action, Depauw and Luz., Strategic Studies Institute, Carlisle Barracks, PA, 1990, 113-126.

37. George A. Joulwan, US Southern Command, "Statement before the Senate Armed Services Committee," Washington, D.C., April 21, 1993.

38. Harvey, "US Military Civic Action in Honduras," 9.

39. John Montalto, MAJ, interview by author, 16 March 1994.

40. Ibid.

41. Harvey, "US Military Civic Action in Honduras," 46.

42. Ibid., 9.

43. Claypool, "Military Medicine as an Instrument of Power," 32.

44. William Stanton, COL, telephone interview with author, 23 January 1994.

45. Claypool, "Military Medicine as an Instrument of Power," 16.

46. The White House, National Security Strategy of the United States, US Government Printing Office (January 1993), 11.

47. US Congress, Report on the Senate Committee on Foreign Relations, Foreign Assistance Act of 1961, US Government Printing Office, Washington, D.C., 1961.

48. Hearings Before the Committee on Foreign Relations of the US Senate, 87th Congress, Act for International Development, US Government Printing Office, Washington D.C., 1961, 27.

49. Anthony Lake, "Designation of A.I.D. Administrator as the Special Coordinator for International Disaster Assistance," Memorandum for the Heads of Executive Departments and Agencies, Washington, D.C., 15 September 1993.

50. Larry Grossman, "A Joint Venture?," Government Executive, (1991): 14.

51. William H. Lyerly, Jr., Political Appointee in African Bureau at USAID, interview by author, telephone interview, 17 February 94.

52. William A. Ward, LTC, Deputy Commandant ARNG Professional Education Center, (ARNG advisor to SOUTHCOM Surgeon, 1990-1991), interview by author, telephone interview, 4 February 94.

53. Ibid.

54. Steven A. Cady, The Country Team: The Critical Interface Between the Department of State and the Department of Defense, Research Report, Maxwell AFB, AL, May, 1991, 27-28.

55. Ibid., 6-8.

56. ElRay Jenkins, Medical Civic Action Programs and Medical Readiness Training Exercises as Instruments of Foreign Policy, 48.

57. Ward, telephone interview.

58. Jose Ciceraro, MSGT, response to author's letter, dated 25 March 1994.

59. Leon Rios, LTC, telephone interview with author, February 1994.

60. Glen Post, Chief, Health, Population and Nutrition Bureau for Latin America and Caribbean, US AID, Interview by author, telephone interview, 2 February 1994.

61. Robert G. Claypool, Military Medicine as an Instrument of Power, 6.

62. Ward, interview.

63. Leon Rios LTC, Chief, Policy and Strategy Division, J-5 SOUTHCOM, telephone interview by author, 4 February 1994.

64. Jose Ciceraro, MSGT, response to author's letter.

65. Lyerly, telephone interview.

66. Ibid.

67. Bradley Mules, LTC, Executive Officer, JRTC Operations Group, telephone interview by author, 21 March 1994.

68. Rios, telephone interview.

69. Ward, telephone interview.

70. Lisa Swerniski, "When the Peace Corps Meets the Army in in a Distant Land," Army, 37 (July 1987): 16-20.

71. ElRay Jenkins, Medical Civic Action Programs and Medical Readiness Training Exercises as Instruments of Foreign Policy, 43-44.

72. Jan Harrington, MAJ, interviewed by author, telephone interview, April 5, 1994.

73. Bernard Harvey, US Military Civic Action in Honduras, 1982-1985, Army-Air Force Center for Low Intensity Conflict, (Langley AFB, VA, 1988), 53.

74. Robert G. Claypool, Military Medicine as an Instrument of Power, An Overview and Assessment, Study project, US Army War College, (Carlisle Barracks, PA, 1989) 30-31.

75. ElRay Jenkins, Medical Civic Action Programs and Medical Readiness Exercises as Instruments of Foreign Policy, 21.

76. Ibid., 24.

77. Marita Patterson, MAJ, Civil Military Operations at USARSO, telephone interview by author, 5 February 1994.

78. Roland J. Weisser, "The Maturing of MEDRETES," Military Medicine, 158, (August 1993): 557-73.

79. This section is a compilation of information gleaned from interviews from the architects of the program as well as various people who have worked in the program.

80. Herbert Temple, LTC (Ret.), telephone interview with author, 5 April 1994.

81. Blacklight exercises were primarily engineer training exercises run in Panama in the 1980's. The exercises were sponsored by the 193rd Infantry and were centered around defense of the canal. They included both active duty and reserve component units rotating in from the US. Medical civic action was accomplished in conjunction with these exercises.

82. Temple, telephone interview.

83. Roger Healy, LTC, telephone interview by author, 21 January 1994.

84. Dennis McKnight, COL, telephone interview with author, 18 January 1994.

85. Healy, telephone interview.

86. Dan Bradford, MAJ, telephone interview with author, 21 January 1994.

87. McKnight, telephone interview.

88. Freese, Ricky, MSG, Personnel Management Supervisor, (Operations NCO and NCOIC of FMTS July 87-July 90), telephone interview by author, 12 April 94.

89. Healy, telephone interview.

90. Freese, telephone interview.

91. Healy, telephone interview.

92. Cheryl Brown, COL, National Guard Bureau, telephone interview by author, 6 April 94.

93. Freese, telephone interview.

94. Freese, telephone interview.

95. Healy, telephone interview.

96. Healy, telephone interview; and Ward, telephone interview.

97. Healy, telephone interview.

98. Jim Crocker, MAJ, telephone interview by author, 11 April 1994.

99. Healy, telephone interview.

100. Ward, telephone interview.

101. Healy, telephone interview.

102. Ibid.

103. Ward, telephone interview.

104. Brent Leesberg, MAJ, telephone interview with author, 25 February 1994.

105. Ibid.

106. Patterson, telephone interview.

107. Michael Navin, COL, Senior ARNG Advisor, interview by author, telephone interview, 13 April 94.

108. Report of the Reserve Forces Policy Board, January 1993, Reserve Component Programs - 1992, Office of the Secretary of Defense, Washington, D.C.

109. John Montalto, MAJ, telephone interview by author, 16 March 1994.

110. Dennis McKnight, COL, telephone interview by author, 14 Jan 94.

111. Defense Almanac, Department of Defense, Washington, D.C., US Government Printing Office, issue 5, 1993, 16.

112. John R. D'Araujo, Jr., Major General, Director, ARNG, letter to author dated 20 May 1994.

Chapter 5

113. John McNamara, CPT, telephone interview with author, 25 February 1994.

114. Anonymous, "US Medical Teams Serving Remote Areas of Latin America," Honduras This Week, 13 March 1993.

115. Radio news, "All Things Considered," National Public Radio, 10 March 1994.

APPENDIX A

MAP OF SOUTHCOM AOR

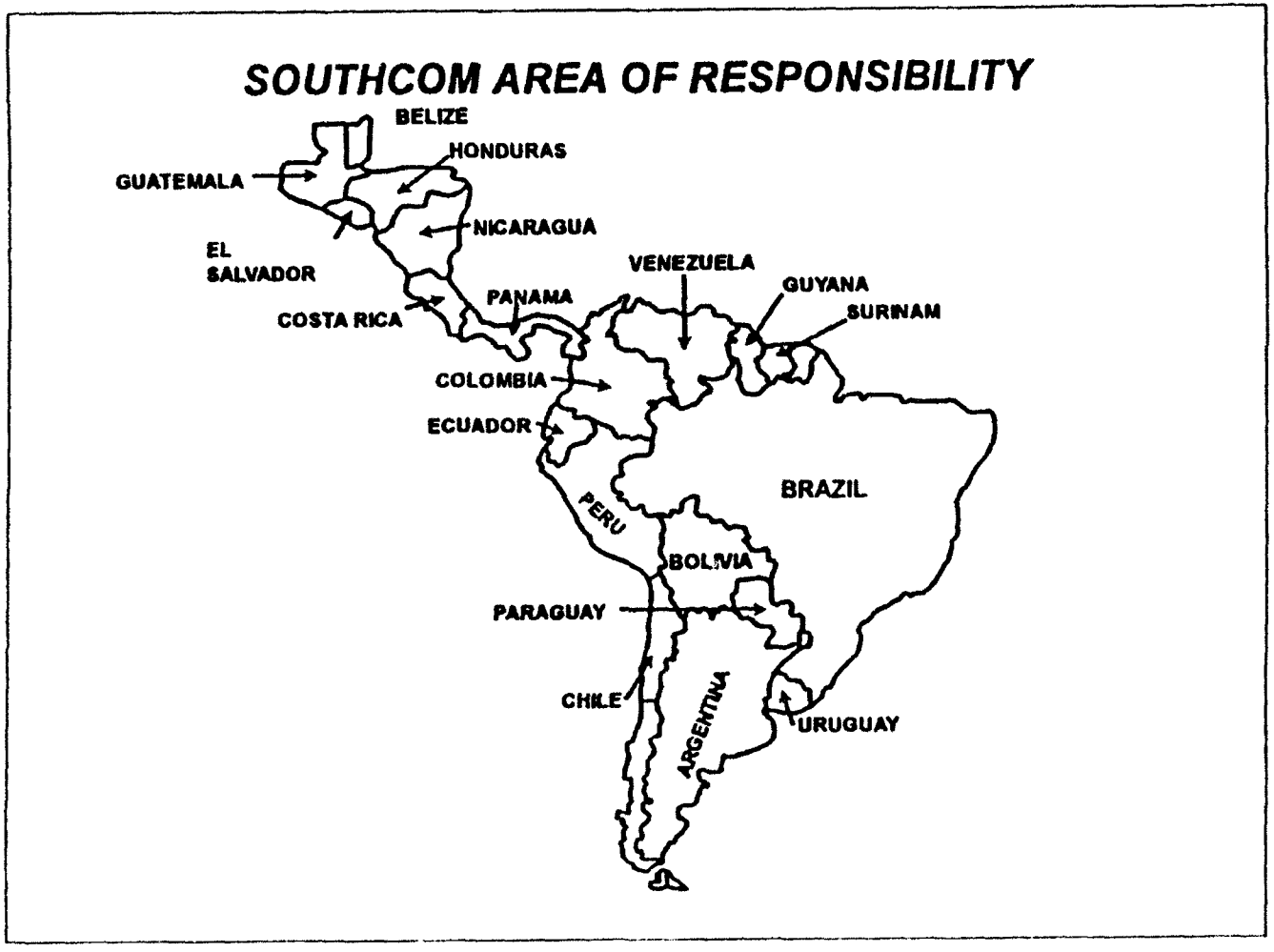

SOUTHCOM AREA OF RESPONSIBILITY
BELIZE
HONDURAS
GUATEMALA
NICARAGUA
EL SALVADOR
VENEZUELA
GUYANA
SURINAM
PANAMA
COSTA RICA
COLOMBIA
ECUADOR
BRAZIL
PERU
BOLIVIA
PARAGUAY
CHILE
ARGENTINA
URUGUAY

Figure 1

APPENDIX B

MEDRETE FREQUENCY CHARTS, FY 92, 93 AND 94

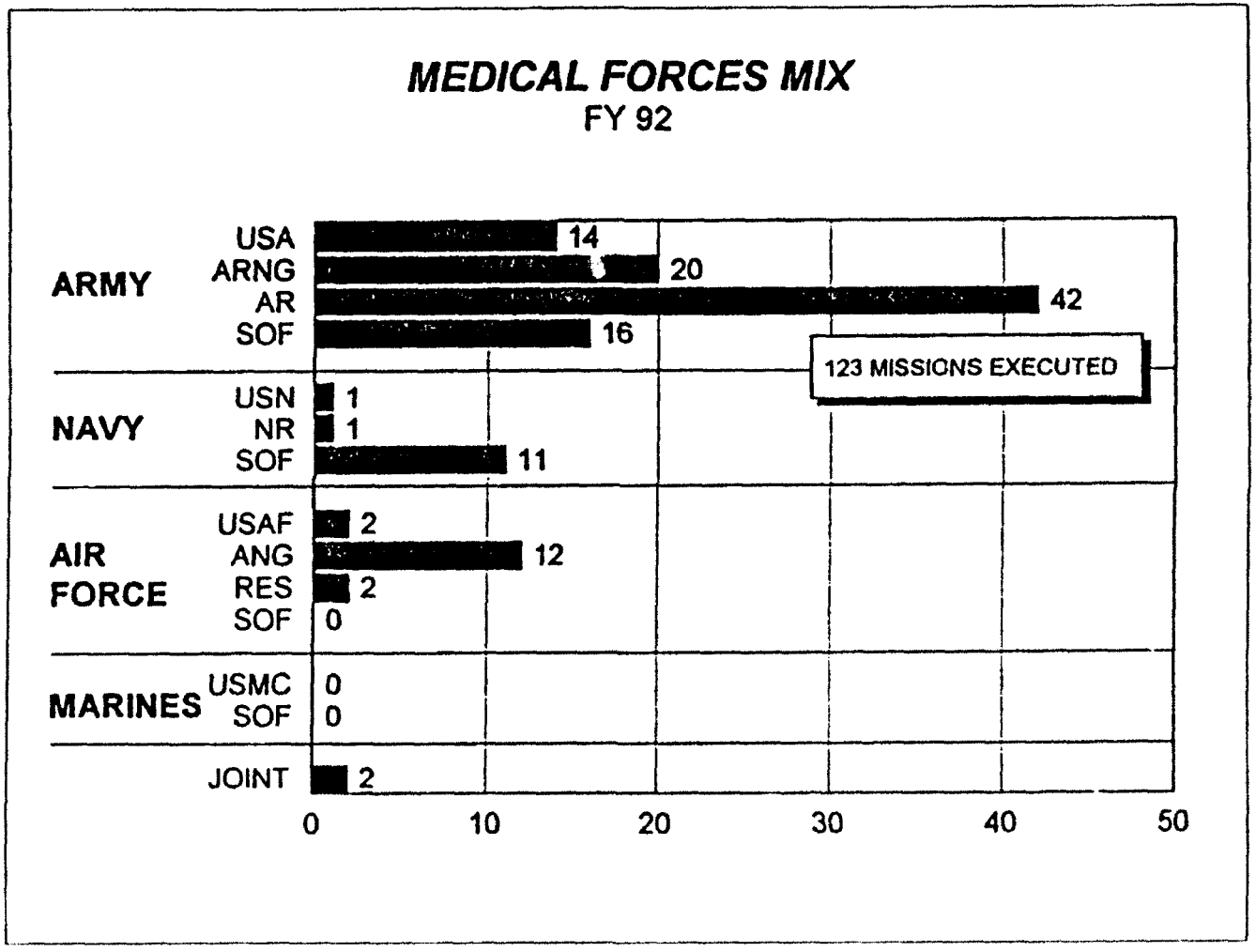


Fig 2. Jose A. Ciceraro, MSGT, USAF, Senior Operations NCO, Office of the Command Surgeon, SOUTCOM, Interview by author, letter, March 25, 1994.

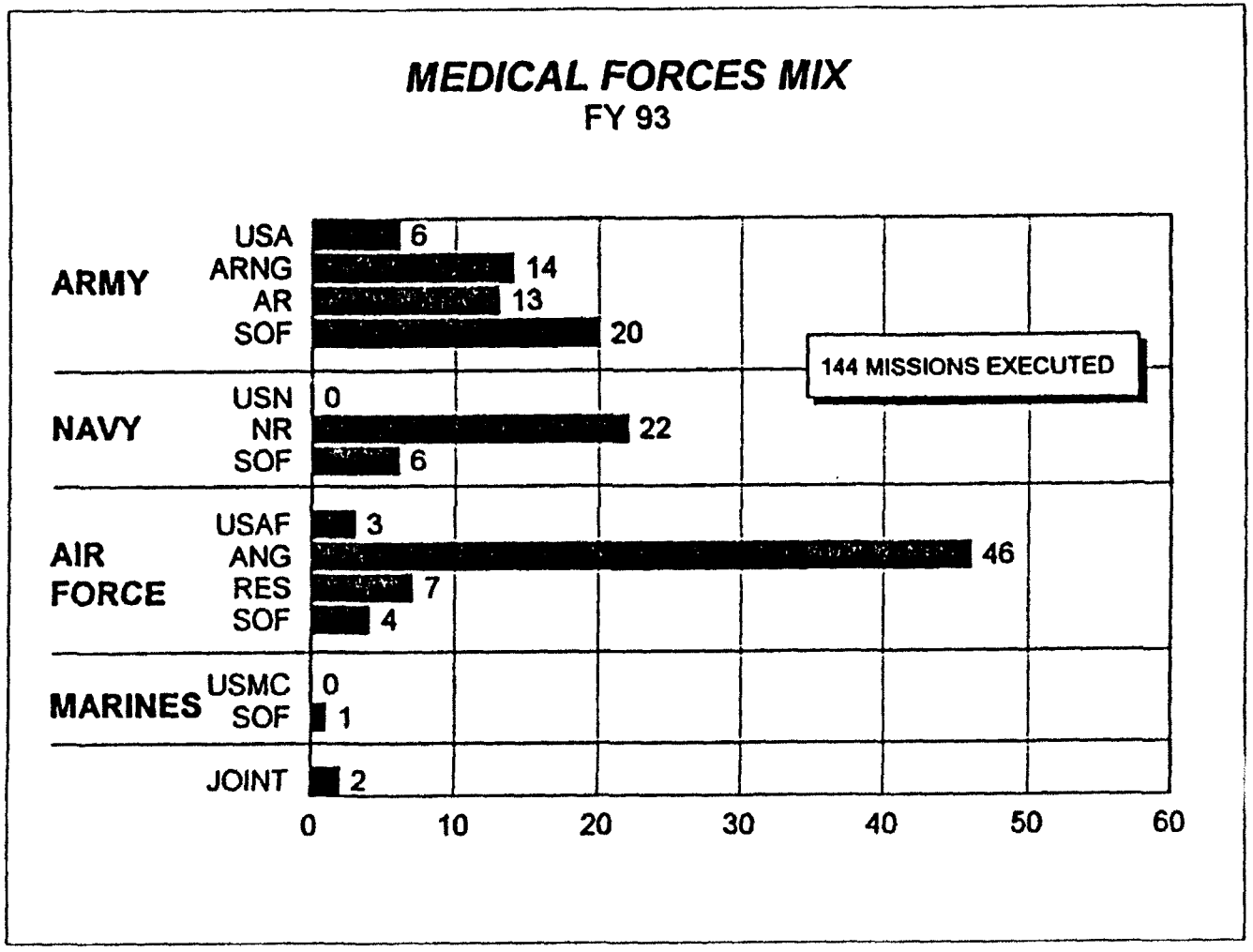


Fig 3. Jose A. Ciceraro, MSGT, USAF, Senior Operations NCO, Office of the Command Surgeon, SOUTHCOM, Interview by author, letter, March 25, 1994.

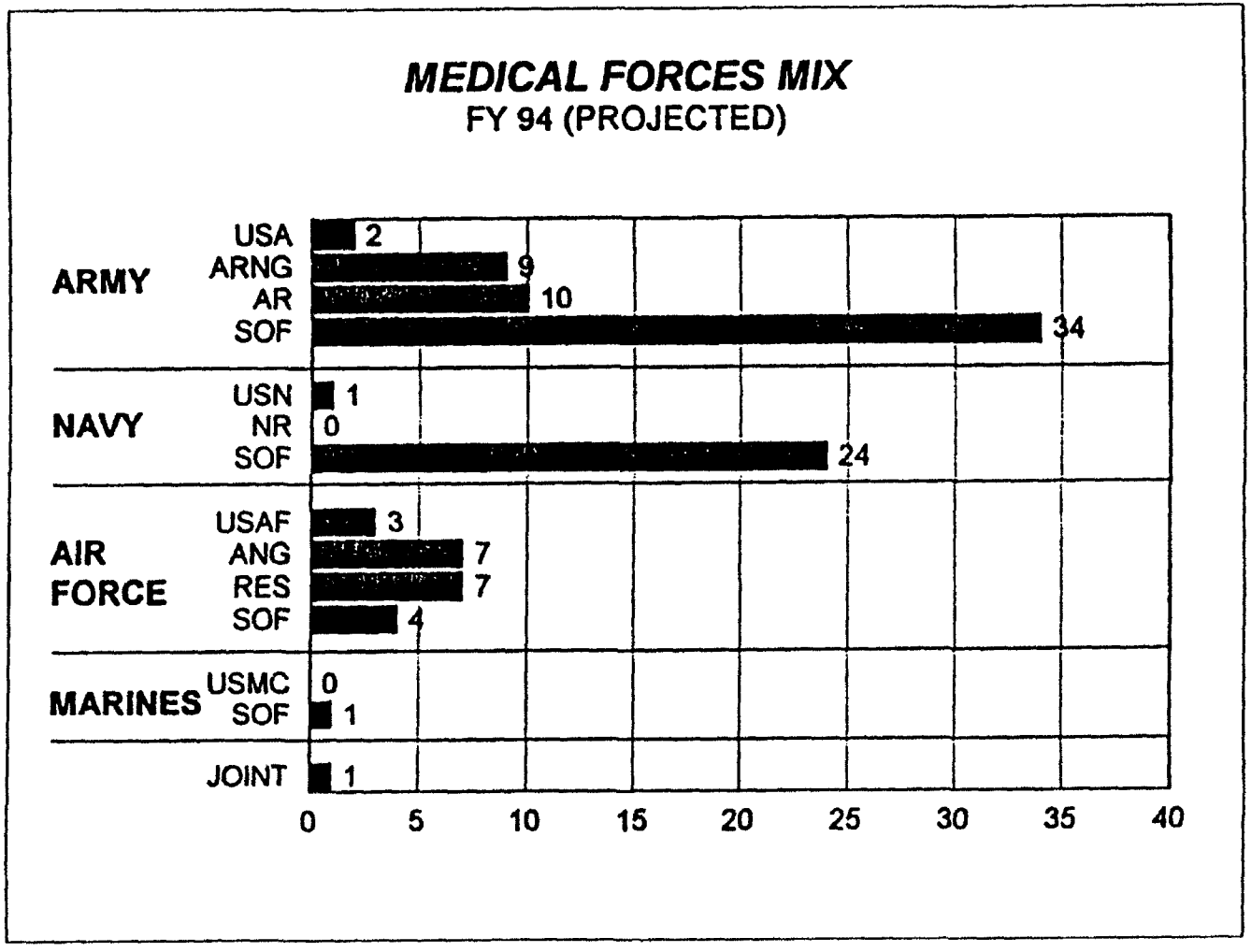


Fig 4. Jose A. Ciceraro, MSGT, USAF, Senior Operations NCO, Office of the Command Surgeon, SOUTHCOM, Interview by author, letter, March 25, 1994.

APPENDIX C

LIST OF ARNG MEDRETES

Table 2.-- ARMY NATIONAL GUARD MEDRETES

MEDRETE	MISSION	UNIT	ST	COMP	START	END	MED	DENT	VET	DOC	YR
PANAMA	BL12	404TH MED DET	AR	ARNG	87/03/12	87/03/26	4492	365	902	4/2/2	87
PANAMA	BL13	159TH MASH	LA	ARNG	87/07/23	87/08/05	2345	684	887	3/2/2	87
PANAMA	BL14	144TH EVAC	UT	ARNG	87/08/27	87/09/04	0	0	1170	3/0/2	87
HONDURAS	88-1	145TH MED CO	OK	ARNG	87/11/02	87/11/19	?	?	?	?/?/?	87
HONDURAS	88-2	145TH MED CO	OK	ARNG	87/11/02	87/11/19	?	?	?	?/?/?	87
PANAMA	88-3	159TH MASH	LA	ARNG	88/01/07	88/01/21	?	?	?	3/?/?	88
HONDURAS	88-4	201ST EVAC	PR	ARNG	88/02/27	88/03/10	1862	524	621	?/?/?	88
HONDURAS	88-5	947TH MED CO	CO	ARNG	88/03/03	88/03/17	?	?	?	4/0/1	88
COSTA RICA	88-6	201ST EVAC	PR	ARNG	88/04/07	88/04/21	1860	525	1543	8/4/0	88
HONDURAS	88-7	730TH MED CO	SD	ARNG	88/05/26	88/06/09	?	?	?	3/?/?	88
PANAMA	88-8	508TH MED CO	IL	ARNG	88/06/09	88/06/23	?	?	?	5/?/?	88
GUATEMALA	88-9	209TH MED	LA	ARNG	88/07/07	88/07/21	?	?	?	5/2/2	88
GUATEMALA	88-10	209TH MED	LA	ARNG	88/08/04	88/08/18	?	?	?	6/?/?	88
HONDURAS	88-11	927TH MED-CLR	FL	ARNG	88/09/01	88/09/15	?	?	?	4/2/1	88
GUATEMALA	89-2	138TH MED CO	GA	ARNG	88/11/05	88/11/19	7182	616	1017	9/2/2	89
BOLIVIA	89-1	657TH MED	MI	USAR	88/11/12	88/11/26	?	?	?	?/?/?	89
BOLIVIA	89-3	HQ STARC	IL	ARNG	88/12/03	88/12/18	2728	942	14881	9/4/3	89
GUATEMALA	89-5	476TH MASH	KY	ARNG	89/02/04	89/02/19	5145	751	1483	3/5/5	89
BOLIVIA	89-6	B/700TH SP BN	OK	ARNG	89/03/11	89/03/25	1735	538	9336	8/1/1	89
BOLIVIA	89-7	245TH MED CO	OK	ARNG	89/04/29	89/05/06	?	?	?	5/2/1	89
GUATEMALA	89-8	245TH MED CO	OK	ARNG	89/05/11	89/05/29	6482	811	8243	4/2/1	89
BOLIVIA	89-9	204TH MED BN	HI	ARNG	89/05/31	89/06/14	3449	598	4562	8/3/3	89
BOLIVIA	89-12	CO B, 204TH MED BN	IL	ARNG	89/05/31	89/06/14	?	?	?	?/?/?	89
PANAMA	89-9	CANCELLED (B,204th SPT)	IL	ARNG	89/06/10	89/06/25	0	0	0	0/0/0	89
COSTA RICA	89-4	148TH EVAC	AR	ARNG	89/07/01	89/07/16	1290	?	1450	2/?/?	89

MEDRETE	MISSION	UNIT	ST	COMP	START	END	MED	DENT	VET	DOC	YR
CHILE	89-10	CANCELLED	XX	XXXX	89/07/05	89/07/19	0	0	0	0/0/0	89
GUATEMALA	89-5	B/29TH SPT GP	HI	ARNG	89/08/03	89/08/17	6963	818	3484	?/?/?	89
GUATEMALA	89-11	29TH SPT GP	HI	ARNG	89/08/03	89/08/17	?	?	?	6/3/1	89
BOLIVIA	90-1	49TH AD	TX	ARNG	89/10/07	89/10/21	4160	1288	0	9/?/0	90
GUATEMALA	90-2	127TH MED GRP	AL	ARNG	89/11/02	89/11/16	7386	6679	4714	5/3/3	90
COSTA RICA	90-3	947TH MED CO	CO	ARNG	90/01/06	90/01/20	2874	1119	2707	9/3/2	90
GUATEMALA	90-4	148TH EVAC	AL	ARNG	90/02/01	90/02/15	7234	761	4472	9/3/3	90
BOLIVIA	90-5	135TH MASH	MO	ARNG	90/03/03	90/03/17	3332	662	13838	7/3/3	90
BOLIVIA	90-6	217TH EVAC	TX	ARNG	90/04/07	90/04/21	2246	463	5511	4/2/1	90
GUATEMALA	90-7	475TH MASH	KY	ARNG	90/05/11	90/05/24	13035	4535	1235	?/?/?	90
BOLIVIA	90-8	807TH MED BDE	TX	USAR	90/06/01	90/06/15	3660	726	5473	?/?/?	90
BOLIVIA	90-9	145TH MED CO	OK	ARNG	90/06/01	90/06/16	6382	391	4118	2/2/1	90
GUATEMALA	90-10	C/108TH SP BN	IL	ARNG	90/08/09	90/08/23	6383	549	2443	4/2/0	90
BOLIVIA	90-11	44TH EVAC	OK	USAR	90/09/01	90/09/15	3660	726	5473	?/?/?	90
GUATEMALA	91-1	127TH MED GRP	AL	ARNG	90/10/30	90/11/16	7386	667	4714	?/?/?	91
GUATEMALA	91-2	217TH EVAC	TX	ARNG	90/11/03	90/11/17	9028	507	8279	4/2/0	91
BOLIVIA	91-3	175TH SPT BN	SD	ARNG	90/12/01	90/12/15	4282	1222	5619	?/?/?	91
COSTA RICA	91-4	192ND SPT BN	PR	ARNG	91/01/12	91/01/26	3044	654	1164	3/2/1	91
BOLIVIA	91-5	947TH MED CO	CO	ARNG	91/03/02	91/03/16	6551	1844	10418	6/3/1	91
COSTA RICA	91-6	192ND SPT BN	PR	ARNG	91/04/06	91/04/20	4332	1426	4001	7/4/1	91
BELIZE	91-9	B/700TH SP BN	OK	ARNG	91/07/06	91/07/20	3220	383	812	5/1/1	91
COSTA RICA	91-8	C/192ND SP BN	PR	ARNG	91/08/08	91/08/22	2382	469	979	9/3/3	91
BOLIVIA	91-11	508TH MED CO	IL	ARNG	91/09/07	91/09/21	3838	731	0	4/2/0	91
COSTA RICA	92-2	135TH MASH	MO	ARNG	91/11/02	91/11/26	3908	746	5325	?/?/?	92
BOLIVIA	92-1	8TH MED BDE	NY	USAR	91/11/30	91/12/14	0	0	5185	0/0/4	92
ECUADOR	92-3	C,192NS SP BN	PR	ARNG	91/11/30	91/12/14	8081	567	5318	5/2/2	92
PANAMA	92-4	135TH MASH	MO	ARNG	92/01/11	92/01/25	1700	1200	30	5/3/3	92

MEDRETE	MISSION	UNIT	ST	COMP	START	END	MED	DENT	VET	DOC	YR
ECUADOR	92-5	C/141 SPT BN	OR	ARNG	92/02/08	92/02/22	3436	872	331	9/2/0	92
GUATEMALA	92-6	209TH MED CO	IA	ARNG	92/03/07	92/03/21	6078	1018	6753	5/2/1	92
BELIZE	92-7	148TH EVAC	AR	ARNG	92/03/28	92/04/11	2472	569	628	?/?/?	92
BOLIVIA	215	369TH EVAC HSP	PR	USAR	92/04/11	92/04/25	6023	504	1313	10/2/1	92
COSTA RICA	92-8	147TH CSH	CO	ARNG	92/05/09	92/05/23	3817	1028	10572	9/3/3	92
BOLIVIA	213	305 FLD HSP	MI	USAR	92/05/16	92/05/30	1039	106	40	?/?/?	92
GUATEMALA	222	807TH MED BDE	TX	USAR	92/06/13	92/06/27	2626	3312	10933	6/3/2	92
ARGENTINA	92-9	C/237TH CS BN	OH	ARNG	92/06/13	92/06/27	5235	2103	5461	9#/3#/3#	92
GUYANA	226	820TH HOSP	PR	USAR	92/07/11	92/07/25	5861	401	799	7/2/#1	92
BOLIVIA	210	201 EVAC HSP	PR	ARNG	92/07/11	92/07/25	2774	387	751	4/2/1	92
COSTA RICA	219	807 MED BDE	LA	USAR	92/08/08	92/08/22	1485	386	3660	8/3/#3	92
GUATEMALA	92-11	112TH MED BDE	OH	ARNG	92/08/08	92/08/22	8672	1625	3439	?/?/?	92
PARAGUAY	92-12	B/204 MED BN	IL	ARNG	92/09/12	92/09/26	2976	403	9034	5/2/1	92
UYANA	227	820TH HSPPR	PR	USAR	92/09/12	92/09/26	2845	560	6585	?/?/?	92
ARGENTINA	3800C	5TH MED GRP	AL	USAR	92/11/07	92/11/21	3113	731	2079	8#/3/2	93
COSTA RICA	3825	201ST EVAC HSP	PR	ARNG	92/11/07	92/11/21	6421	1018	3283	6#/2#/2#	93
ECUADOR	3810C	343RD EVAC HSP	NY	USAR	92/11/22	92/12/15	4703	2964	1146	6#/3#/2#	93
PARAGUAY	3880C	5TH MED GRP	AL	USAR	92/12/05	92/12/19	5448	301	831	?/?/?	93
PARAGUAY	3811C	109TH EVAC HSP	AL	ARNG	93/01/09	93/01/23	4656	1096	745	6/2/1	93
GUATEMALA	3838C	5501ST USAH	MN	USAR	93/01/09	93/01/23	16730	1132	865	?/?/?	93
GUATEMALA	3820C	204TH MED BN	MN	ARNG	93/02/06	93/02/20	9446	869	1655	5/3/2#	93
PARAGUAY	3881C	159TH MASH	LA	ARNG	93/02/06	93/02/20	5899	1314	2880	9/2/1	93
ECUADOR	3831C	C/108TH SUP BN	IL	ARNG	93/03/06	93/03/20	4313	1124	3217	7/2/2	93
GUYANA	3860C	396TH STA HSP	MT	USAR	93/03/06	93/03/20	2733	433	132	8/3/3#	93
ECUADOR	3832	120TH MED BN	OK	ARNG	93/03/27	93/04/10	6021	1470	2423	9#/3#/2	93
PANAMA	3812C	109TH MED BN	IA	ARNG	93/04/12	93/05/12	4479	1429	929	?/?/?	93
ECUADOR	3830C	94TH GEN HSP	TX	USAR	93/04/12	93/05/01	5786	1263	3113	7/3/2	93

MEDRETE	MISSION	UNIT	ST	COMP	START	END	MED	DENT	VET	DOC	YR
COSTA RICA	3826	136TH CSH	MD	ARNG	93/05/03	93/05/22	4040	1251	3748	11#/3#/1#	93
PARAGUAY	3882C LTT	07TH MED BDE	TX	USAR	93/05/29	93/06/12	NA	NA	NA	NA	93
GUATEMALA	3839C	193RD SPT BN - CANCELLED	PR	ARNG	93/06/05	93/06/19	CXL	NA	NA	NA	93
PANAMA	3814C	2291ST USAH	OH	USAR	93/06/09	93/06/19	3653	1054	1777	7#/3#/1	93
GUATEMALA	3840C	5501ST USAH - CANCELLED	IL	USAR	93/07/10	93/07/24	CXL	NA	NA	NA	93
ECUADOR	3833C	120TH MD BN	OK	ARNG	93/07/10	93/07/24	4318	815	1799	9#/3#/1#	93
GUATEMALA	3841C	13TH CSH	WI	ARNG	93/08/07	93/08/21	5386	803	3317	6#/3#/2#	93
BELIZE	3805	135th MASH	MO	ARNG	93/08/07	93/08/21	1853	264	NA	5#/2#/NA	93
PARAGUAY	3883C LTT	C,108TH SPT BN	IL	ARNG	93/08/27	93/09/14	NA	NA	NA	NA	93
ECUADOR	3834C	C,192ND SPT BN	PR	ARNG	93/09/04	93/09/18	11,784	1,254	3,052	7#/2#/1	93
ECUADOR	45998B	148TH EVAC HSP	AR	ARNG	93/11/06	93/11/20	5224	586	NA	4/2/NA	94
GUATEMALA	45988B	475TH MASH	KY	ARNG	94/01/08	94/01/22					94
BOLIVIA	45983B	508TH MED CO	IL	ARNG	94/03/05	94/03/19					94
COSTA RICA	45993B	700TH SPT BN	OK	ARNG	94/04/16	94/04/30					94
ECUADOR	45999B	135TH MASH	MO	ARNG	94/05/07	94/05/21					94
COSTA RICA	45004C	730TH MED CO	SD	ARNG	94/06/04	94/06/18					94
ECUADOR	45986B	2071ST MED CO	MI	ARNG	94/07/16	94/07/23					94
PARAGUAY	45995B	300TH CSH	TN	ARNG	94/08/13	94/08/27					94
ECUADOR	46001C	145TH ME									

Source: MAJ Marita Patterson, Civil Military Operations, USARSO

CODES

MEDRETE = Country where MEDRETE executed.
UNIT = Unit performing MEDRETE.
ST = State unit assigned.
COMP = Component of unit, (ARNG, USAR or AC).
START = Start date of MEDRETE.
END = End date of MEDRETE.
MED = Number of persons seen, (not procedures accomplished.)
DENT = See MED.
VET = See MED.
DOC = Number of Physicians/Dentists/ Vetrinarians deployed, (# means a unit had to go outside organic unit to fill requirements). The requirement until FY 94 was 9/3/3. (In 1994 all veterinarian authorizations were lost to the ARNG)

APPENDIX D

ARNG/USAR MEDICAL END STRENGTH AND FORCE STRUCTURE

THE ASPIN DEAL

ARNG - USAR "OFF-SITE" TRADE-OFF AGREEMENT

FROM ARNG TO USAR	LOST SPACES	FROM USAR TO ARNG	AMOUNT GAIN	MF2K UNITS REMAINING IN ARNG	TOTAL SPACES
1 MED BDE (CORPS)	-69	7 AIR AMB CO	819	3 MASH	399
1 MED GRP	-58			3 EVAC BN	129
9 PREV MED (SANI)	-99			12 AIR AMB CO	1404
4 PREV MED (ENTO)	-44			8 GND AMB CO	819
DEN SVC DET	-200			5 SURG SQD	45
CSH	-1158			5 ASMB	1585
				2 DEN SVC CO	112
				38 ARNG	4493
				'+ 7 USAR AIR AMB CO	819
TOTAL 26 UNITS	-1646	7	819	TOTAL 45	5312
			NET -829		

ALL NUMBER ARE MF2K CONVERSION MTO&E

NUMBERS DO NOT INCLUDE FSB OR MSE AMEDD SOLDIERS

Fig 5. Jon R. Beckenhauer, COL, Senior ARNG Advisor, Office of the Army Surgeon General, provided charts in response to telephonic request by author, March, 1994.

ARMY NATIONAL GUARD

TO&E MEDICAL FORCE STRUCTURE

TAA01 & MF2K & OFF SITE AGREEMENT

FUNCTIONAL AREA	1992	1994	1996	1997 ?
HOSPITALS	25	7	6	3
EVACUATION	44	23	24	30
DENTAL	43	7	10	2
MED BDE	3	2	1	0
GROUPS (MF2K)	3	2	1	0
AREA SUPPORT	0	3	5	5
PREVENTIVE MEDICINE	0	9	13	0
MED SURG TEAMS	0	0	5	5
LABS	1	0	0	0
VET DETACHMENTS	2	0	0	0
DISPENSARIES	44	0	0	0
CLEARING COMPANY	19	0	0	0
LOGISTICS	1	1	0	0
TOTAL PEOPLE	17350	16173	6723	5312
NUMBER LOST		1177 (-7%)	10627 (-61%)	12038 (-71%)

DOES NOT INCLUDE FSB & MSB OR PROPOSED STATE HEALTH AND DENTAL CLINICS
THE TRUTH AS IT IS TODAY 1 JANUARY 1994.

Fig 6. Jon R. Beckenhauer, COL, Senior ARNG Advisor, Office of the Army Surgeon General, provided charts in response to telephonic request by author, March, 1994.

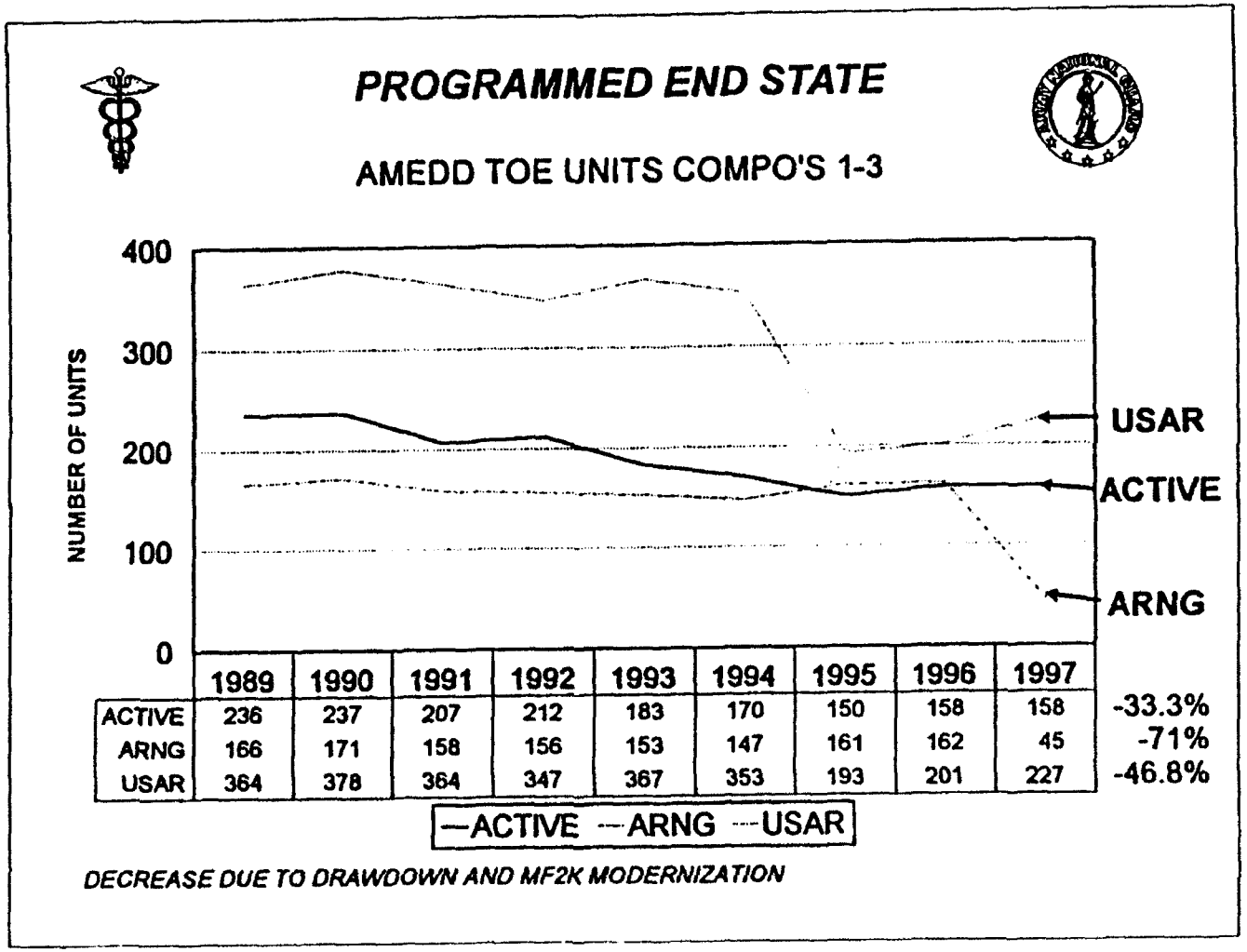


Fig 7. Jon R. Beckenhauer, COL, Senior ARNG Advisor, Office of the Army Surgeon General, provided charts in response to telephonic request by author, March, 1994.

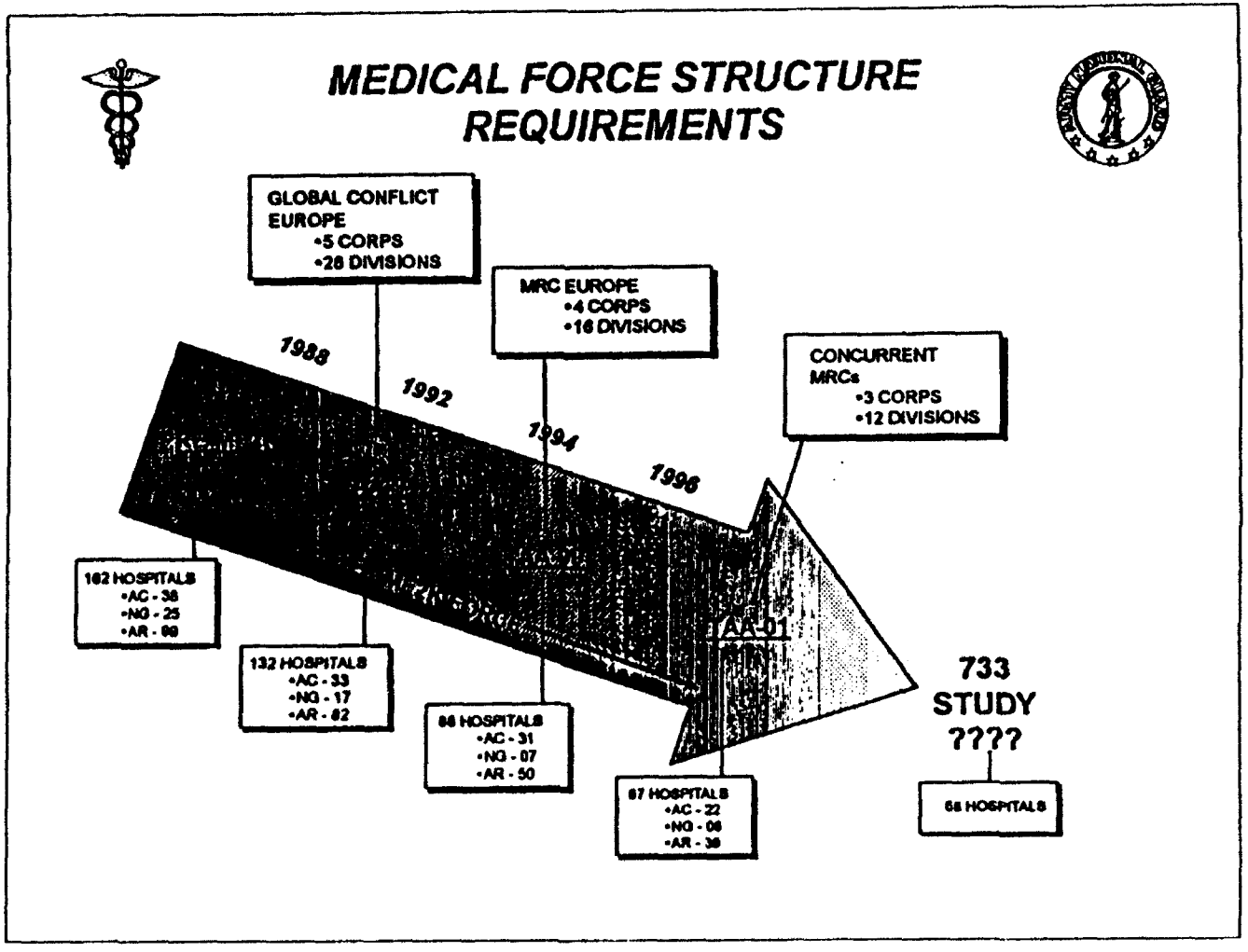
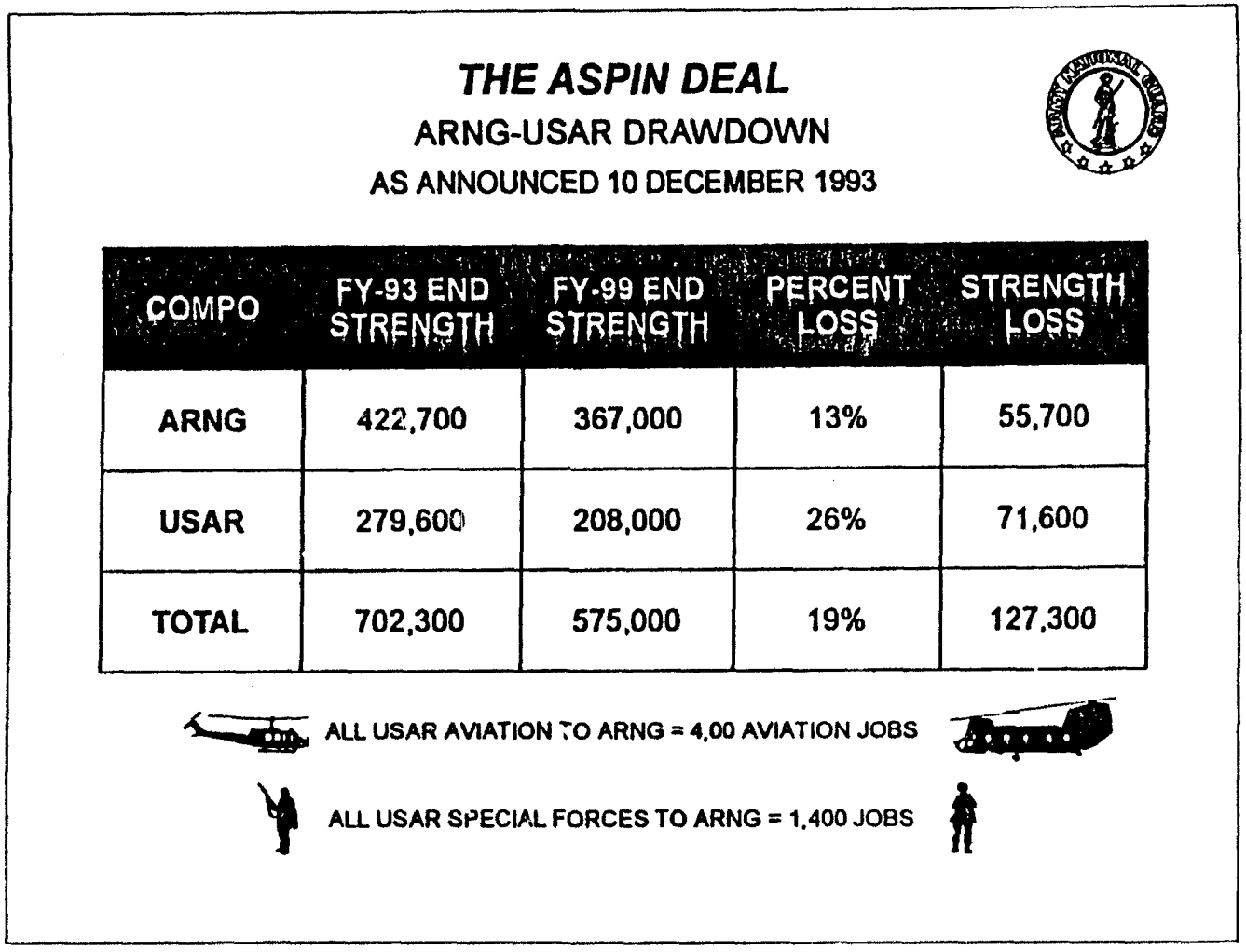


Fig 8. Jon R. Beckenhauer, COL, Senior ARNG Advisor, Office of the Army Surgeon General, provided charts in response to telephonic request by author, March, 1994.



COMPO	FY-93 END STRENGTH	FY-99 END STRENGTH	PERCENT LOSS	STRENGTH LOSS
ARNG	422,700	367,000	13%	55,700
USAR	279,600	208,000	26%	71,600
TOTAL	702,300	575,000	19%	127,300

Fig 9. Jon R. Beckenhauer, COL, Senior ARNG Advisor, Office of the Army Surgeon General, provided charts in response to telephonic request by author, March, 1994.

APPENDIX E

FORMATS FOR

MEDRETE/MCA LEADER'S RECONNAISSANCE WORKSHEET

AND

MEDRETE AFTER ACTION REPORT

FROM MEMORANDUM OF INSTRUCTION HQ US ARMY SOUTH

ANNEX A

MEDRETE/MCA LEADER'S RECONNAISSANCE WORKSHEET

EXERCISE DATE: _____

USARSO UNIT: _____

ODT UNIT: _____ Component _____ Address _____

_____

ODT POC: _____ TELE: _____ _____

_____

PAX (# deploying) USARSO: _____ ODT: _____

NAME OF PROVINCE/DEPARTMENT: _____

SITES	MAP SHEET	GRID COORD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOPOGRAPHY: _____

CLIMATE: _____

COMMUNICATIONS ON SITE: _____

REMARKS: _____

_____

_____

_____

_____

NAMES OF LOCAL LEADERS/ADDRESSES (medical, gov't, etc.):

_____

_____

_____

_____

_____

_____

_____

HOST NATION SECURITY: Available YES_____ NO_____

TYPE OF BUILDING FOR TREATMENT:

	SITE 1	SITE 2	SITE 3	SITE 4
Building:				
Potable Water:				
Electricity:				
Refrigeration:				

GENERAL INFORMATION (living conditions, income level, items of interest):

_____
_____
_____
_____

ACCESS: Are roads available? YES____ NO____ Condition___

LOCAL COMMUNICATIONS AVAILABLE:_____
TELEPHONE NUMBERS:_____

PATIENT INFORMATION:

Number of children < 1 year:_____

Number of children 1-15 years:_____

Number of adults:_____

Population of surrounding areas:_____

Estimated number of patients to be treated:_____

Number of deaths in last three months:_____

Reason(s) for deaths:_____

VETERINARY INFORMATION:

Number of cattle: _____
Number of horses: _____
Number of sheep/goats: _____
Number of pigs: _____
Number of poultry: _____
Number of dogs/cats: _____
TOTAL ANIMAL POPULATION: _____

SPECIFIC ANIMAL DISEASES:

Nutritional: _____
Parasites: _____
Rabies: _____
Equine: _____
Bovine: _____
Hog cholera: _____
Canine: _____
Feline: _____
Other: _____
_____

TYPE OF VETERINARY FACILITIES AVAILABLE (corral, posts, shoot, etc: _____
_____

SKETCH OF VILLAGE:

SECURITY REQUIREMENTS:
U.S.: _____
Host Nation: _____
Plan:

RON LODGING/FACILITIES AVAILABLE:

BILLETING: _____
LATRINES: _____
FOOD: _____
SHOWERS: _____

SKETCH OF TREATMENT AREA(s) (include triage, screening, de-worming, pharmacy, dental and medical exams, and veterinary area):

FLIGHT INFORMATION:

LZ Capability (UH60, UH1, etc):_____
LZ Sketch: (include hazards - wires, trees, buildings etc)

MEDEVAC INFORMATION:

Nearest local facility for stabilization/treatment:_____
_____
POC at local health facility:_____
Telephone numbers of local health facilities:_____
Method of transportation to local facility:_____
_____

TEAM COMPOSITION (# personnel)

DUTY AOC/MOS	US	RP
a. Physicians	_____	_____
b. Dentists	_____	_____
c. Veterinarians	_____	_____
d. Medical Specialists (91A, B)	_____	_____
e. Licensed Practical Nurses (91C)	_____	_____
f. Dental Technicians	_____	_____
g. Veterinary Technicians	_____	_____
h. Pharmacy Technicians	_____	_____
i. Preventive Medicine Personnel	_____	_____
j. Communications Representative	_____	_____
k. Command and Control	_____	_____
l. Other	_____	_____
TOTALS	_____	_____

ANNEX B

MEDRETE AFTER ACTION REPORT

1. Country:

2. File number:

3. Period covered:

4. Unit:

5. Training objectives achieved:

6. Locations visited:

7. Information on other participating units and support provided:

8. Transportation used:

9. Patient statistical data:

    a. Number of patients seen:

    b. Number of mission personnel seen as patients:

10. Preventive medicine concerns:

11. Veterinary data:

12. Medical evacuation summary:

13. Communications summary:

14. Questionnaire:

    a. Characterize the impacts of the terrain and vegetation on the medical mission:

        (1) Hardstand suitability and clearing for the establishment of your medical facility.

        (2) Drainage.

        (3) Dust and sand - impact regarding degradation potential to personnel and medical equipment.

        (4) Trafficability of road nets and cross country movement for ground evacuation and transport.

(5) Sites for aeromedical evacuation (LZ and runways).

(6) Protection from winds and weather.

(7) Cover and concealment:

(8) Estimate of risk potential from natural phenomena based on information from local sources (volcanic debris, high earthquake activity, flooding, tidal wave, fire).

b. Characterize the impacts of local climatology on the medical mission:

(1) Performance degradation due to extremes of temperature and humidity.

(2) Solar radiation.

(3) Precipitation.

(4) Flooding.

(5) Extremes in elevation.

c. Characterize the demographic profile in the immediate operational area:

(1) Age and sex of individuals screened and patients.

(2) Estimate of infant mortality.*

(3) Estimate of the general fertility rate.*

(4) Estimate the literacy rate (indigenous language) for males and females.*

d. Characterize indigenous customs and religious practices that may impact medical care given by U.S. and host nation care providers:

(1) Predominant religious/spiritual belief(s).

(2) Medical practices contraindicated by religion or custom.

(3) Traditional practices that impact health (Medicinal herbs, rituals, scarification rites).

e. Characterize indigenous substance abuse practice and potential medical/social impact:

(1) List the types of substances used by the local population medical/social impact:

(2) List the local names given these substances.

(3) Characterize the physiological and behavioral effects produced by these substances if determined that they are not common to western knowledge.

(4) Describe the medical/social impacts on the population: (Examples: Low birth weight, substance dependency at birth, adult dependency, etc.).

(5) Identify components of the population significantly affected by abuse of these substances: (Example: Military personnel, males in the labor sector over 15 years of age, village elders concurrent with religious/ceremonial practice).

f. Describe indigenous dietary practices that would characterize the nutritional status of the local population:

(1) General composition of the local diet.

(2) Traditional nutritional practices that may affect health: (Examples: Fasting, avoidance of certain foods, preparation practices).

(3) Observed nutritional deficiencies.

(4) Record height, weight, and age of children under seven years of age.

g. Characterize the level of sanitation affecting the indigenous standard of living and potential for the spread of communicable disease in the local area of operation:

(1) Describe water sources (surface/groundwater) and quantity available.

(2) Characterize local physical and biological water quality. (If treated, describe method(s) used).

(3) Estimate percent of community access to potable water.

(4) Estimate percentage of community access to adequate sewage disposal. (Describe method used and ultimate disposal location and effluent quality.)

(5) Describe local methods of solid waste disposal.

(6) Describe local methods for hazardous waste disposal.

(7) Describe health and social impacts of significant air water pollution problems in the local area.

h. Characterize veterinary health and veterinary public health conditions affecting the local populace in the area at the time of the operation:

(1) List types of domestic animals and utility within the local community: (Example: Food, draft, transportation, breeding stock.)

(2) List significant domestic animal veterinary health problems.

(3) Describe the impact of zoonotic disease within the local community.

(4) Describe veterinary public health problems caused by feral animals in the operational area.

(5) Characterize any government sponsored veterinary health programs operating in the local area of operations.

(6) List veterinary drugs and vaccines that are commonly available in the indigenous area.

i. Identify hazardous vertebrates and invertebrates within the local area of operations that significantly impact health and quality of life:

(1) List hazardous vertebrates having most significant health impact.

(2) List hazardous invertebrates having most significant impact.

(3) Describe local treatment practices dealing with the treatment of a bite or sting of hazardous vertebrates and invertebrates.

(4) Describe unique local methods of hazardous vertebrate and invertebrate avoidance.

j. Identify hazardous plants within the local area of operations that significantly impact health and quality of life:

(1) List hazardous plants having most significant health impact.

(2) Describe local treatment practices dealing with the treatment of contact with or ingestion of hazardous plants in the local operational area.

k. Describe vector control problems within the local area of operations:

(1) List significant communicable disease vectors in the local area.

(2) Describe vector control methods being employed by communities and family units within the local area.

l. Characterize the prevalence * of endemic communicable diseases infecting the population in the area of operation at the time of the operation:

(1) Diseases with short incubation periods.

(a) Acute diarrheal, diseases (salmonellosis, shigellosis, campylobacter, Escherichia coli).

(b) Enteric protozoal diseases (amebiasis, giardiasis, cryptosporidiosis).

(c) Malaria (vivax, falciparum, etc.).

(d) Arboviral fevers (dengue, viral encephalitides, St. Louis encephalitis, Eastern, Western, and Venezuelan equine encephalitis).

(e) Typhoid and paratyphoid fevers.

(f) Sexually transmitted diseases (syphilis, gonorrhea, etc).

(g) Leptospirosis.

(h) Meningococcal meningitis.

(i) Acute respiratory diseases.

(2) Diseases with long incubation periods.

(a) Viral hepatitis.

(b) Leishmaniasis.

(c) Zoonotic diseases (rabies, brucellosis, toxoplasmosis).

(d) Vectorborne diseases (Chagas' disease, tickborne rickettoses).

(e) Sexually transmitted diseases (HIV).

(f) Other infectious diseases (soil transmitted helminthic infections, tuberculosis, acute hemorrhagic conjunctivitis, filariasis, histoplasmosis, aseptic meningitis).

m. Describe health care capabilities in the area with respect to the following subject areas:

(1) Health care infrastructure at the local area.

(2) Local disaster contingency planning.

(3) Emergency medical capabilities.

(4) Medical Evacuation resources (air/ground/waterborne).

(5) Medical treatment facilities.

(6) Medical Personnel: Training and qualifications.

(7) Public health education practice.

(8) Maternal and child health programs.

(9) Immunization programs. (List immunizations given the local population.)

(10) Medical material (pharmaceutical, medical supplies, and equipment).

(11) Blood and blood products to include storage capabilities.

(12) Foreign donor support activities in the local operational area, less that provided the U.S.

n. Describe dental care capabilities in the area with respect to the following subject areas:

(1) Report Decayed (D), Missing (M), and filled (F) (DMF) Index for the following age groups: 1-5 years, 6-12 years, 13-21 years, and >22 years for the patient population in the area of operations.

(2) Report reasons for oral surgery; in the local patient population: (Extraction, trauma, periodontal disease, decay, other pathology).

(3) Report number of deciduous, mixed vs. permanent dentition in the patient population.

(4) Report any observable dental malady affecting the local population judged to result from an environmental or nutritionally related circumstance.

(5) Report any dental practice that is a result of local tradition or custom within the population.

(6) Dental treatment facilities and capabilities.

(7) Dental Personnel: Training and qualifications.

o. Describe local military health care capabilities with respect to the following subject areas:

(1) Medical Evacuation resources (air/ground/waterborne).

(2) Medical Facilities (Clinictertiary Referral facilities).

(3) Medical Personnel: Training and qualifications.

(4) Unit sanitation training and discipline.

(5) Dependent health care operations.

(6) Medical Material.

(7) Blood and blood product management.

(8) National disaster/emergency planning and participatory role of military assets.

(9) Civic action/humanitarian projects.

(10) Foreign military medical support or advisors, less that provided by the U.S.

15. Problems encountered:

16. Recommendations:

17. Lessons learned:

ANNEX B-1

FORMULAS

DMF Index: An individual's caries experience is represented by the total number of teeth decayed (D), missing (M), and filled (F) teeth. This score constitutes the DMF tooth count (DMFT) for an individual. The sum of the individual DMF scores divided by the number of individuals examined constitutes the average DMF score for the population. For the primary deciduous teeth, the index is modified to include only the decayed and filled teeth.

```
Sum of individual DMFT scores
---------divided by---------- = DMF Index
Number of individuals examined
```

General Fertility Rate: The number of live births per 1,000 women ages 15-49 years in a given year. (The age of childbearing women is arbitrarily assumed for statistical purposes to be 15-49 years.)

```
Number of births
--divided by----- x 1,000 = General Fertility Rate
Number of women
    15-49
```

Infant Mortality Rate: The number of deaths to infants under one year of age in a given year per 1,000 live births in that year.

```
Number of deaths to
infant under age 1
-----divided by------ x 1,000 = Infant Mortality Rate
 Total live births
```

Literacy Rate: The number of individuals per 1,000 persons in a given population that have the ability to read and write their indigenous language.

```
Number of literates
------divided by-------- x 1,000 = Literacy Rate
  Total population
```

Prevalence Rate: The number of persons having a particular disease at a given point in time per 1,000 population at risk. This rate includes all previously existing cases as well as new cases developing during the specified period.

Number of persons with a specified disease -----divided by--------- x 1,000 = Prevalence Rate Total population at risk

BIBLIOGRAPHY

Government Documents and Studies

Brehm, Philip A. Alternative Missions for the Army. Strategic Studies Institute, Carlisle Barracks, U.S. Army War College, 1992.

_____ _. Restructuring the Army: The Road to a Total Force. Strategic Studies Institute, Carlisle Barracks, U.S. Army War College, 1992.

Cady, Steven A. The Country Team: The Critical Interface Between the Department of State and the Department of Defense. Research Report, Maxwell AFB, AL, May 1991.

Claypool, Robert G. Military Medicine as an Instrument of Power: An Overview and Assessment. US Army War College, Carlisle Barracks, 1989.

Cramblet, Peter R. U.S. Medical Imperatives for Low Intensity Conflict. US Army War College, Carlisle Barracks, 1991.

DePauw, John W., Luz, George A. Winning the Peace: The Strategic Implications of Military Civic Action. Strategic Studies Institute, US Army War College, Carlisle Barracks, 1990.

Gosnell, Paul W. Time to build, An Expanded Role for the United States Reserve Forces in Central America and the Caribbean. Monograph, Inter-American Defense College, Washington D.C., 1988.

Graham, James R., ed. Non-Combat Roles for the U.S. Military in the Post Cold War Era. Institute for National Strategic Studies, National Defense University Press, Fort Lesley McNair, Washington, D.C., 1993.

Harvey, Bernard E. US Military Civic Action in Honduras, 1982-1985: Tactical Success, Strategic Uncertainty. Army-Air Force Center for Low Intensity Conflict, Langley Air Force Base, VA, 1988.

Heller, Charles E. The New Military Strategy and its Impact on the Reserve Components. Strategic Studies Institute, US Army War College, Carlisle Barracks, 1991.

Jenkins, ElRay. Medical Civic Action Programs (MEDCAPS) and Medical Readiness Training Programs (MEDRETES) as Instruments of Foreign Policy. US Army War College, Carlisle Barracks, 1988

Kowalewski, Edward S. The Reserve Component Strategic Option. US Army War College, Carlisle Barracks, 1988.

Luckett, Joseph L. Reserve Component Overseas Deployment Training: A Key Instrument within the Elements of Power. US Army War College, Carlisle Barracks, 1990.

Nunn, Sam. Domestic Missions for the Armed Forces. Strategic Studies Institute, US Army War College, Carlisle Barracks, 1993.

Ohlinger, Brian. Peacetime Engagement: A Search for Relevance. Strategic Studies Institute, US Army War College (Carlisle Barracks, PA) 1992.

Sewell, Thomas K. U.S. Reserve Component Training in U.S. Southern Command--An Example of Total Army Concept. US Army War College, Carlisle Barracks, 1988.

Thornton, William H. Army Medical Department, Roles and Functions in Low Intensity Conflict. US Army War College, Carlisle Barracks, 1987.

Testimony/Hearings

Statement of General George A. Joulwan. Commander in Chief, U.S. Southern Command, presented before the Senate Armed Services Committee, Washington, D.C., April, 21, 1993.

Hearings before the Comittee in Foreign Relations of the U.S. Senate, 87th Congress, Act for International Development, US Government Printing Office, Washington D.C., 1961.

Reports

Convergence and Community: The Americas in 1993. A report of the Inter-American Dialogue, The Aspen Institute, Washington, D.C., 1992.

Report of the Reserve Forces Policy Board. January 1993, Reserve Component Programs, Office of the Secretary of Defense, Washington, D.C., 1992.

GAO Study. "Changes Needed to the Humanitarian and Civic Assistance Program." General Accounting Office, Washington, DC, 2 November, 1993.

Lee, Deborah. "On 20th Anniversary Total Force is Real and No Longer a Concept." Reserve Officer Association National Security Report. Reserve Officer's Association of the US, September 1993.

Lee, Deborah. "US Military Changes Mean Greater Reliance Will Be Placed on Reserve Forces." Reserve Officer Association National Security Report, Reserve Officer's Association of the US, March 94.

Articles

Anonymous. "US Medical Teams Serving Remote Rural Areas of Latin America." Honduras This Week, (March 13, 1993).

Bradford, Dan. "Panama's Fort Kobbe Houses Medical POMCUS." National Guard, Vol XLI, No. 11 (November 1987): 34.

Carter, William E., III. "Planning for Medical Readiness Training Exercise." Army Logistician, (May-June 1994): 35-37.

Gavin, Todd. "Injured Bosnisn Chidren find Refuge at MASH." HSC Mercury, Vol 21, No. 3 (December 1993): 1.

Hood, Charles Hardin. "The United States Medical Department in Low Intensity Conflict." Military Medicine, Vol 156 (February 1991): 664-67.

Matthews, John L. "A Force Structure Solution We Can Support." National Guard, Vol XLVIII, No. 1 (January 1994): 2.

Matthews, William. "Guard Troops Used to Fight Urban, Rural Ills." Army Times, (June 28, 1993).

Matthews, William. "Ready to Go Units Aim for a Greater Role." Army Times, (August 16, 1993).

Noyes, Harry. "US Medics to Serve U.N. in Croatia." HSC Mercury Vol 20, No. 11 (August 1993): 9.

Swenarski, Lisa. "When the Peace Corps Meets the Army in a Distance Land." Army, Vol 37, No. 7, (July 1987): 16-20.

Taylor, James A. "Military Medicine's Role in Low Intensity Conflict." Military Review, Vol LXV, No. 4 (April 1985): 26-34.

Ward, William A., David A. Bradford and Jose A. Ciceraro, "A Critical Part of Nation Assistance." Military Review, Vol LXXIII, No. 3, (March 1993): 36-40.

Weisser, Roland J. "The Maturing of MEDRETES." Military Medicine, Vol 158 (August 1993): 573-575.

Wittich, Arthur, C. "The Medical Care Syatem and Medical Readiness Training Exercises (MEDRETES) in Honduras." Military Medicine, Vol 154 (January 1989): 19-23.

Zajtchuk, Russel, William F. Brown, and James H. Rumbaugh, "Medical Success in El Salvador." Military Medicine, Vol 154 (February 1989): 59-61.

Interviews and Oral Histories

Beckenhauer, Jon, COL, MS, NEARNG. Senior ARNG Advisor, Office of the Army Surgeon General, Faxed information and data in response to request by author, March 1994.

Bradford, Dan, MAJ, MS, UTRNG. National Guard Bureau, medical logistics, (First FMTS Commander), Telephone interview by author, 21 January 1994.

Ciceraro, Jose, MSGT, Senior Medical Operations NCO, Office of Command Surgeon, SOUTHCOM, Response to author's letter dated 25 March 1994.

Crocker, James, CPT, MS, MOARNG. National Guard Bureau, Medical operations, Telephone interview by author, 11 April 1994.

D'Araujo, John R., Jr., Major General, Director Army National Guard, Response to author's letter dated 20 May 1994.

Freese, Ricky, MSG. (NCOIC of FMTS 1989-1990), National Guard Bureau, Personnel Directorate, Telephone interview by author, 12 April 1994.

Harrington, Jan, MAJ, MS, NEARNG. National Guard Bureau, Aviation Directorate, (Chief, AMEDD Recruiting and Retention, 1991-1993), Telephone interview by author, 5 April 1994.

Healy, Roger, LTC, MS, UTARNG. Health Services Command. (Second FMTS Commander), Telephone interview by author, 21 January 1994.

Leesberg, Brent, MAJ, ARNG Liaison, attached U.S. MILGP, Guatemala, 25 February 1994.

Lyerly, Bill H. Lyerly, Political Appointee in African Bureau at AID, Washington, D.C., Telephone interview by author, 17 February 1994.

McKnight, Dennis, COL, MSC, PAARNG. National Guard Bureau, Office of the Chief of Staff. Telephone interview by author, 18 January 1994. (Developed concept for FMTS.)

Mcnamara, John CPT. Army Counter Drug Advisor, MILGP, Ecuador, 25 February 1994.

Montalto, John, MAJ, MS, USAR. CGSC Student, (Medical Operations Officer, USARSO, 1986-1988), Personal interview with author, 16 March 1994.

Mules, Bradley, LTC, Executive Officer, JRTC, Operations Group. Telephone interview by author, 21 March 1994.

Nevin, Michael, COL, IN. Senior ARNG Advisor, USARSO, Telephone interview by author, 13 April 1994.

Patterson, Marita, MAJ, MS, NMARNG. Civil Military Operations at USARSO, Telephone interview by author, 5 February 1994.

Post, Glen. Chief, Health Population and Nutrition Bureau for Latin America and Carribbean, USAID, 2 February 1994.

Leon Rios, LTC, Chief, Policy and Strategy Division, J-5, SOUTHCOM, 4 February 1994.

Stanton, William, COL, VC, MSARNG. 213th Medical Brigade, (ARNG Medical Representative in SOUTHCOM 1985-1989), Telephone interview by author, 23 January 1994.

Temple, Herbert, LTG(Ret), Previous Chief, National Guard Bureau, Telephone interview by author, 5 April 1994.

Ward, William, LTC, DC, ALARNG. ARNG Professional Education Center, (SOUTHCOM Surgeon's Office, 1990-1991), Telephone Interview by Author, 28 January 1994.

Government Publications

HQ Department of the Army. "AR 40-3, Medical, Dental, and Veterinary Care." Washington, DC, Government Printing Office, 15 February 1985.

HQ US Army South. Memorandum of Instruction, Medical Readiness Training Exercises/Medical Civic Action. Fort Clayton, Panama, January 1992.

HQ US Army South. Reg 40-2, Medical Services, Medical Readiness Training Exercises/Medical Civic Action. Fort Clayton, Panama, April 1988.

US Army Southern Command. Reg 40-6, Medical Services, Administration of Medical Deployments for Training. Quarry Heights, Panama, Sept 1991.

HQ Department of the Army. FM 100-5, Operations, Washington D.C., Government Printing Office, 14 Jun 1993.

Department of Defense. Defense Almanac, Washington, D.C., Government Printing Office, Issue #5, 1993.

HQ Department of the Army. "AR 40-1, Medical Services, Composition, Mission and Functions of the Army Medical Department." Washington D.C., Government Printing Office, 1 July 1983.

HQ Department of the Army. FM 41-10, Civil Affairs Operations. Washington, D.C., Government Printing Office, 11 January 1993.

HQ Department of the Army. FM 8-10, Health Service Support in a Theater of Operations." Washington, D.C., Government Printing Office, 1 March 1991.

HQ Department of the Army. FM 100-9, Domestic Support Operations. Washington, DC, Government Printing Office, Washington, DC, July 1993.

HQ Department of the Army. FM-42, Medical Operations in Low Intensity Conflict." Washington, DC, Government Printing Office, December 1990.

The White House. "National Security Strategy of the United States." Government Printing Office, Washington, D.C., January 1993.

Chairman, Joint Chiefs of Staff. "The National Miltary Strategy of the United States." Washington, DC: GPO, January 1992.

United States Code Annotated. Title 10, Armed Forces, Chap 20, "Humanitarian and Other Assistance." West Publishing Company, St Paul, Minnesota, (1993): 144-146.

Books

Cosmas, Graham A. and Albert E. Cowdrey. US Army in World War II, The Medical Department: Medical Service in The European Theater of Operations. Center of Military History, United States Army, Washington D.C., 1992.

Cowdrey, Albert E. United States Army in the Korean War, The Medic's War, Center of Military History. United States Army, Washington, D.C., 1987.

Glick, Edward B. Peaceful Conflict: The Non-Military Use of the Military. Stackpole Books, Harrisburg Pennsyvania, 1967.

Neel, Spurgeon, MAJ GEN. Vietnam Studies Medical Support. Department of the Army, Washington, D.C., 1973.

Summers, Harry G., Jr. On Strategy, a Critical Analysis of the Vietnam War. Presidio Press, Novato, California, 1982.

Unpublished Material

Herrick, Charles R. "Misadventure in Nation Building or...Why Pedro Hates Gringos." (Submitted for Publication).

HQ Department of the Army. FM 8-42, Health Service Support in Operations Other than War (Initial Draft)." US Army Medical Department Center and School, Fort Sam Houston, Texas, October 1993.

Zaytchuk, Russ, BG, MC. "Humanitarian Assistance and Domestic Support Conference, 2-3 June 1993." Brooke Army Medical Center, Fort Sam Houston, Texas, Memorandum dated 19 July 1993.

INITIAL DISTRIBUTION LIST

1. Combined Arms Research Library
   U.S. Army Command and General Staff College
   Fort Leavenworth, KS 66027-6900

2. Defense Technical Information Center
   Cameron Station
   Alexandria, VA 22314

3. LTC Geoffrey B. Demarest
   Foreign Military Studies Office
   Fort Leavenworth, KS 666027-6900

4. LTC Dwain L. Crowson
   Reserve Affairs
   USACGSC
   Fort Leavenworth, KS 66027-6900

5. LTC Philip Wyssling
   DSRO
   USACGSC
   Fort Leavenworth, KS 66027-6900

6. William H. Lylerly
   Agency for Internationl Development
   Bureau for Africa
   Department of State
   Washington, D.C. 20523

7. Stimson Library
   AMEDD Center & School
   Fort Sam Houston
   San Antonio, TX 78234-6100

8. Army National Guard
   Support Service ATTN: ARZ-RS
   111 S. George Mason Drive
   Arlington, VA 22212

CERTIFICATION FOR MMAS DISTRIBUTION STATEMENT

1. Certification Date: ___/___/___

2. Thesis Author: Nancy Fortuin

3. Thesis Title: Army National Guard Medical Readiness Training Exercizes in SOUTHCOM

4. Thesis Committee Members Signatures: Luann R Crowson

5. Distribution Statement: See distribution statements A-X on reverse, then circle appropriate distribution statement letter code below:

(A) B C D E F X SEE EXPLANATION OF CODES ON REVERSE

If your thesis does not fit into any of the above categories or is classified, you must coordinate with the classified section at CARL.

6. Justification: Justification is required for any distribution other than described in Distribution Statement A. All or part of a thesis may justify distribution limitation. See limitation justification statements 1-10 on reverse, then list, below, the statement(s) that applies (apply) to your thesis and corresponding chapters/sections and pages. Follow sample format shown below:

S A M P L E	Limitation Justification Statement	Chapter/Section	Page(s)	S A M P L E
	SAMPLE	SAMPLE	SAMPLE	
	Direct Military Support (10)	Chapter 3	12	
	Critical Technology (3)	Sect. 4	31	
	Administrative Operational Use (7)	Chapter 2	13-32	
	SAMPLE	SAMPLE	SAMPLE	

Fill in limitation justification for your thesis below:

Limitation Justification Statement	Chapter/Section	Page(s)

7. MMAS Thesis Author's Signature: Nancy A. Fortuin

STATEMENT A: Approved for public release; distribution is unlimited. (Documents with this statement may be made available or sold to the general public and foreign nationals).

STATEMENT B: Distribution authorized to U.S. Government agencies only (insert reason and date ON REVERSE OF THIS FORM). Currently used reasons for imposing this statement include the following:

1. Foreign Government Information. Protection of foreign information.

2. Proprietary Information. Protection of proprietary information not owned by the U.S. Government.

3. Critical Technology. Protection and control of critical technology including technical data with potential military application.

4. Test and Evaluation. Protection of test and evaluation of commercial production or military hardware.

5. Contractor Performance Evaluation. Protection of information involving contractor performance evaluation.

6. Premature Dissemination. Protection of information involving systems or hardware from premature dissemination.

7. Administrative/Operational Use. Protection of information restricted to official use or for administrative or operational purposes.

8. Software Documentation. Protection of software documentation - release only in accordance with the provisions of DoD Instruction 7930.2.

9. Specific Authority. Protection of information required by a specific authority.

10. Direct Military Support. To protect export-controlled technical data of such military significance that release for purposes other than direct support of DoD-approved activities may jeopardize a U.S. military advantage.

STATEMENT C: Distribution authorized to U.S. Government agencies and their contractors: (REASON AND DATE). Currently most used reasons are 1, 3, 7, 8, and 9 above.

STATEMENT D: Distribution authorized to DoD and U.S. DoD contractors only; (REASON AND DATE). Currently most used reasons are 1, 3, 7, 8, and 9 above.

STATEMENT E: Distribution authorized to DoD only; (REASON AND DATE). Currently most used reasons are 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.

STATEMENT F: Further dissemination only as directed by (controlling DoD office and date), or higher DoD authority. Used when the DoD originator determines that information is subject to special dissemination limitation specified by paragraph 4-505, DoD 5200.1-R.

STATEMENT X: Distribution authorized to U.S. Government agencies and private individuals of enterprises eligible to obtain export-controlled technical data in accordance with DoD Directive 5230.25; (date). Controlling DoD office is (insert).